Psychosocial & Mental Health Needs Following Major Emergencies

A GUIDANCE DOCUMENT

Prepared by a multi-agency group for the
HSE National Vision for Change Working Group

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

A Vision for Change
ADVANCING MENTAL HEALTH
IN IRELAND

Foreword

In this country Major Emergencies are relatively rare, although events in recent years have shown that we are not completely immune from their damaging consequences. Whenever a Major Emergency occurs the Health Service must be in a position to mobilise an appropriate and effective response so as to provide relevant support and assistance to all who may need it. This response must be delivered in cooperation with our colleague Principal Response Agencies, i.e., An Garda Síochána and the Local Authorities, as well as a spectrum of other responding organisations, including the Defence Forces, the Irish Coast Guard, the Voluntary Emergency Services and Community Organisations.

The functions of individual organisations and the way in which their joint efforts are coordinated in the response to a Major Emergency are set out in **"A Framework for Major Emergency Management"**, which was issued by the Government in September 2006. The functions of the Health Service, as set out in the Framework, include the treatment and care of victims with physical injuries as well as the "provision of psychosocial support to persons affected by the emergency".

This Guidance Document is intended to assist managers and individuals within the Health Service to understand the practical steps required, in terms of both preparation and response, in order to provide the necessary psychosocial support to persons affected by a Major Emergency. As part of that process the document sets out the theoretical background to the proposals made which are heavily influenced by international best practice as set out in, for example, reports on the topic by the NATO Joint Medical Committee and the European Network for Traumatic Stress.

The Psychology Service will play a key role in the management of the psychosocial response of the Health Service to any Major Emergency. However if that response is to be efficient and effective it must operate smoothly alongside the responses of other sections of the Health Service, including, the National Ambulance Service and the Acute Hospital Service. For that reason it is important that key individuals in all relevant parts of the Health Service are familiar with the contents of this document.

Finally, this document deals with the provision of psychosocial support to members of the public in the aftermath of a Major Emergency. The Health Service has other documents and processes which deal with the provision of psychosocial support to staff members who have been involved in the response to a Major Emergency.

It is expected that this Guidance Document will assist local Health Service areas in preparing effective responses to the psychosocial and mental health consequences for survivors and the public following Major Emergencies.

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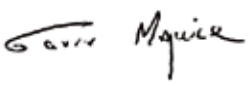

Assistant National Director
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Contents

Recommended Health Service Actions

1. Develop a comprehensive national implementation plan to support this Guidance Document.

2. Adopt and implement, at regional level, the national policies and procedures that support an effective psychosocial response in the aftermath of a Major Emergency.

3. Assign to the relevant Principal Psychology Manager in each area the key role of leading the Health Service psychosocial response, including the development of and responsibility for governance structures.

4. Nominate a national panel of experts in the area of psychosocial care which will be available to advise Health Service Management as required.

5. Engage at both national and regional levels with the external agencies, whose collaboration and cooperation is required in order to deliver effective psychosocial support, during and in the aftermath of Major Emergencies, so as to ensure that plans are integrated, responsive and provide predictable services.

6. Ensure that psychosocial and mental health care responses are integrated with the strategic and operational planning and action processes of health service Major Emergency Management.

7. Plan and prepare so that psychosocial and mental health care responses in the aftermath of Major Emergencies will be comprehensive, stepped according to needs, of sufficient duration and well co-ordinated.

8. Embed psychosocial response to Major Emergencies within existing health service communications' policy and infrastructure, including social media.

9. Develop quality assured information resources at national level which allow for local adaptation regarding the signposting of local supports and services.

10. Conduct an annual audit in each area using the template in Appendix 4.

11. Develop relevant educational material which supports the Health Service and partner agencies in fulfilling their roles in delivering the Strategic Stepped Model of Care.

12. Enhance Service Level Agreements with funded agencies in the social care area in order to to ensure psychosocial responses are provided to agreed standards.

Key Terms and Definitions:

Throughout this document the following terms are used as per the definitions below. A further list of Major Emergency terms and definitions are included in Appendix 2.

A **Major Emergency** is any event which, usually with little or no warning, causes or threatens death or injury, serious disruption of essential services or damage to property, the environment or infrastructure beyond the normal capabilities of the principal emergency services in the area in which the event occurs, and requires the activation of specific additional procedures and the mobilisation of additional resources to ensure an effective, co-ordinated response.

Framework for Major Emergency Management is a Framework enabling An Garda Síochána, the Health Service and Local Authorities to prepare for and make a co-ordinated response to Major Emergencies resulting from events such as fires, transport accidents, hazardous substance incidents and severe weather, see www.mem.ie.

Psychosocial refers to the full spectrum of psychological, emotional, social, relationship, behavioural, cognitive and physical experiences. These can occur within individuals and between groups of individuals, e.g. families, communities, and work groups, in the context of particular social and physical environments. For the purpose of this Guidance Document the focus is on these processes as they occur before, during and after Major Emergencies.

Psychosocial Care incorporates emotional and practical help. It ranges from providing immediate comfort and practical help through to longer term psychological support and specialist trauma care.

Psychosocial Approach refers to the process of planning and delivering a coordinated range of healthcare responses to the psychological and mental health needs of individuals, in tandem with a parallel series of social, welfare and other non-healthcare responses.

Reaction describes the range of experiences, difficulties, problems and health difficulties that may affect people following Major Emergencies.

Need refers to requirements for assistance from relatives, other people, and formal services that individuals may require as a consequence of their exposure to Major Emergencies.

Response refers to the ways in which societies, communities, relatives, and formal services act to meet the needs of communities and individuals after Major Emergencies.

Personal Psychosocial Resilience is defined as the capacity of an individual to adapt reasonably well, psychologically, emotionally and physically, and without lasting detriment to self, relationships or personal development, in the face of adversity, threat or challenge.

Psychological First Aid (PFA) is an evidence-informed approach that is designed to reduce the initial distress caused by traumatic events and to foster short-term and long-term adaptive functioning and coping.

SECTION 1

INTRODUCTION

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SECTION 1: INTRODUCTION

1.1 Background

Major Emergencies of whatever nature (transport accident, flooding, storm or fire) create a wide range of psychological and social challenges at individual, family, and community levels. Major Emergencies create acute short term impacts but also have the potential to undermine the long-term mental health and psychosocial well-being of affected populations.

A significant priority in the psychosocial response to a Major Emergency is to support and promote the resilience and resourcefulness of individuals and communities in a manner that helps to lessen the impact of the event.

The Health Service has primary responsibility for the provision of psychosocial care to members of the public affected by Major Emergencies. This document provides information on the psychosocial impact of these events and describes a management system and model of service delivery for planning and delivering effective responses to the psychosocial and mental health needs of individuals and communities after Major Emergencies.

This Guidance Document is intended to assist local Health Service areas in preparing effective responses to the psychosocial and mental health consequences for individuals and communities following Major Emergencies. It identifies the pathways which the individuals who are affected are likely to follow and how their needs can be met through Primary Care and professional partnerships. It is supported by the current evidence based theory and practice.

This guidance should enable local planning for psychosocial response to be integrated into existing services within a common national strategy. The guidance also has applicability for those planning for and responding to significant traumatic events and critical incidents which have a large-scale impact but which do not involve the declaration of a Major Emergency.

It is recognised that this is an arena of ongoing significant research attention and that current thinking and practice may well be superseded by future developments. Therefore this Guidance Document should be seen as an evolving one that will need adaptation in the light of future new perspectives.

This Guidance Document is informed and heavily influenced by international sources of expertise that reflect the insights of practitioners from different disciplines and sectors and an emerging consensus on good practice.

Key sources included;

- North Atlantic Treaty Organisation (NATO) Joint Medical Committee - Psychosocial Care for people affected by Major Emergencies - A model for designing, delivering and managing psychosocial services for people involved in major incidents, conflict, disasters and terrorisms, Sept 2008.
- The European Network for Traumatic Stress – www.tentsproject.eu
- Guidance for Responding to the Psychosocial and Mental Health Needs of People Affected by Disasters or Major Incidents. NATO/TENTS (2009)

Practitioners need to be aware that this Guidance Document should be implemented in the context of the wider Major Emergency Management Framework and its associated structures and documentation. For that reason practitioners are advised to read carefully the "Framework for Major Emergency Management" which was issued by the Government in 2006. The Framework sets out the responsibilities of An Garda Síochána, the Health Service Executive and Local Authorities (known as the Principal Response Agencies) in preparing for and delivering a coordinated response to Major Emergencies resulting from events such as fires, transport accidents, hazardous substance incidents and severe weather. The Framework sets out inter-agency structures and processes for planning for Major Emergencies as well as the structures and arrangements which underpin the response to these events.

1.2 Vision

The Health Service aims to implement an integrated and coordinated psychosocial response to Major Emergencies. It aims to ensure, as far as possible, that all individuals, families and communities experiencing or at risk of experiencing psychological, emotional, social and physical (psychosocial) experiences and/or mental health sequelae will receive a continuum of supports from health and community service providers who will understand the issues and who will recognise and respond to the needs of those impacted.

SECTION 2

THE PSYCHOSOCIAL ROADMAP

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SECTION 2: THE PSYCHOSOCIAL ROADMAP

2.1 How People Respond To Emergencies

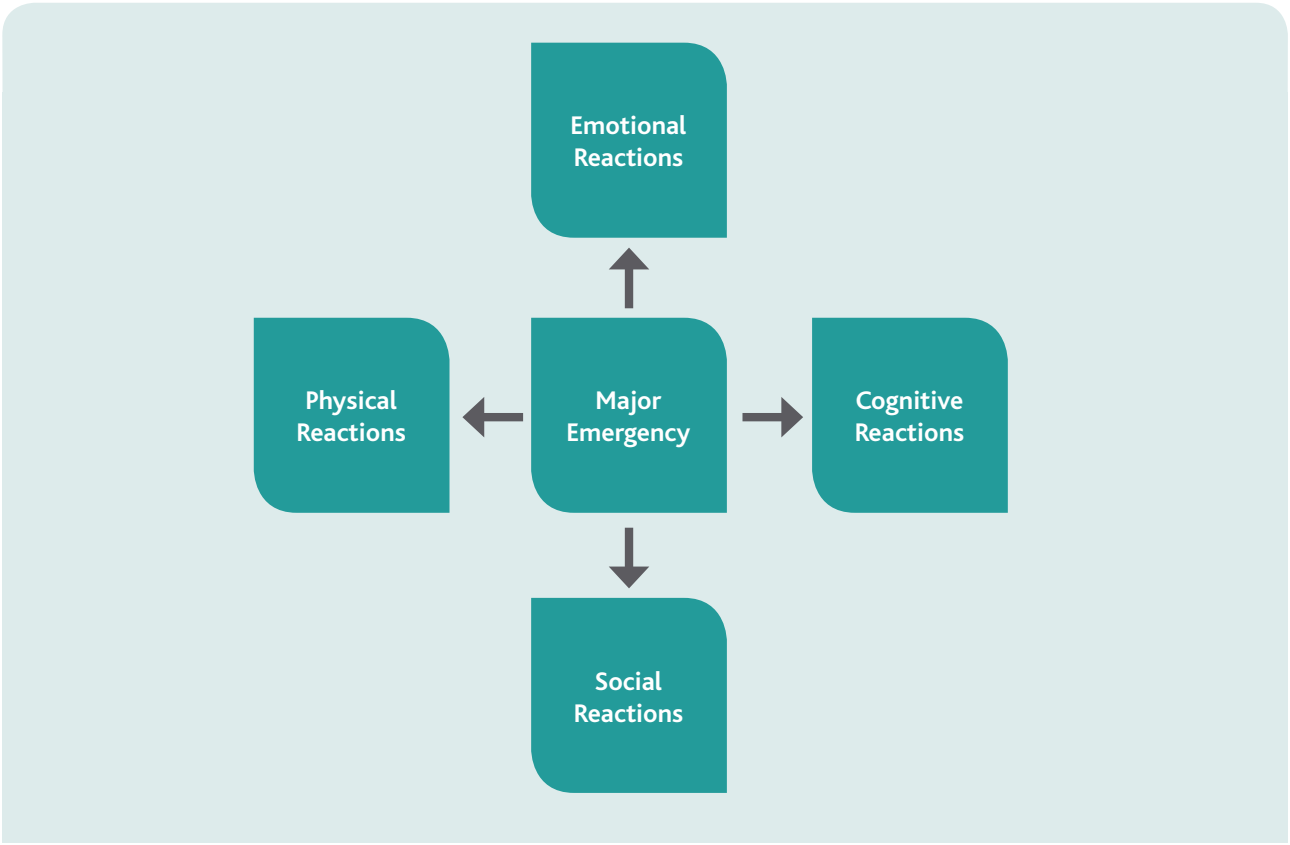
Major Emergencies evoke a variety of responses in people and any one individual may also experience a spectrum of reactions within quite short timeframes, ranging from coping to being overwhelmed.

NORMAL REACTIONS TO TRAUMATIC EVENTS

Traumatic events commonly impact on all aspects of an individual's functioning, including physical (biological), emotional, behavioural, cognitive and spiritual. These experiences may be of very variable intensity and duration. Provided these experiences are short-lived, they might be considered to be "normal" in the context of "abnormal" circumstances and, as such, they are anticipated. Immediate or early reactions are illustrated in Figure 1. This Figure is taken from "Early mental health intervention after disaster", Alexander, D. (2005) Advances in Psychiatric Treatment 11, 12-18

The NATO documentation indicates that up to 75% of survivors of disasters show no mental health difficulties; although, transitory psychological experiences, best described as distress, are regularly exhibited and these are sometimes accompanied by dysfunction. It further estimates that a substantial proportion, perhaps between 20% and 40%, of affected people may experience more sustained distress that lasts more than several days, grows in severity after the events or their involvement in them have subsided, but, usually, diminish within a month of their disengagement from or resolution of a critical situation.

Figure 1: *- The Nature of Anticipated Immediate Reactions to Major Incidents – Adapted From Alexander, 2005*



PSYCHOLOGICAL REACTIONS		SOCIAL REACTIONS	PHYSICAL REACTIONS
Emotional Reactions	Cognitive Reactions		
Shock and Numbness	Impaired Memory	Regression	Insomnia
Fear and Anxiety	Impaired Concentration	Withdrawal	Hyperarousal
Helplessness and/or Hopelessness	Confusion or Disorientation	Irritability	Headache
Fear of Recurrence	Intrusive thoughts, Dissociation or Denial	Interpersonal Conflict	Somatic Complaints
Guilt	Reduced Confidence or Self-Esteem	Avoidance	Reduced Appetite
Anhedonia	Hypervigilance		Reduced Energy
Anger			

LONGER TERM IMPACT

Current knowledge about resilience, risk and protective factors indicates that it is difficult to predict who is likely to recover from their immediate reactions or from distress, with support from families or the provision of community and welfare services, and who may have more sustained distress or develop a mental disorder. (Table 1 identifies potential risk factors).

Studies estimating the proportion of affected people who go on to develop mental disorders demonstrate considerable variability, ranging from 0 to 99% (Steel et al, 2009). The most typical, but by no means exclusive, types of health difficulties include anxiety states, depression, post-traumatic stress disorder, and substance misuse. Bunting et al. (2013), in a Northern Ireland epidemiological survey, note the lifetime prevalence of any mental health disorder among men and women as 27.2% and 31.1%, respectively. This did not include those who had been caught up in conflict related events. The lifetime and 12-month prevalence of PTSD were 8.8% and 5.1%, respectively. For children, following the New York City 9/11attack, the most prevalent diagnoses were agoraphobia 14.8%, separation anxiety 12.3%, and PTSD 10.6% (NATO, 2008).

In the literature there is information on a generalised pattern of how populations respond over time to traumatic experiences. In the first instance, there is a high frequency of people responding with proportionate distress very soon after a Major Emergency. This is followed by an initial significant and then more gradual reduction in these frequencies in the weeks and months after an event. However, some people may go on to develop a longer-term mental disorder.

The NATO documentation includes estimates, from the literature, that approximately 75% of people recover psychosocially without requiring expert intervention, but rather relying on the care, assistance and good relationships with their families and friends and the support of their communities. However this proportion varies with the nature of the Major Emergency and the circumstances of the individuals involved. For example, in the case of flooding, the most frequent type of natural disaster, the research suggests that the psychosocial impact is particularly prevalent and prolonged.

For flood victims, therefore, the psychosocial and mental health consequences can have a long tail and there may be a number of peaks and troughs. This may be because people's homes and livelihoods are directly affected and recovery, including financial and material recompense, can take a long time.

FOUR BROAD PATTERNS OF CONTINUING REPONSES

Research suggest a number of key patterns of individual responses

Group 1: ***Resistant people who show transient distress***

- People in this group are minimally upset.

Group 2: ***Resilient people who show distress (two subgroups)***

- People who are proportionately, mildly, temporarily, and predictably upset in the immediate aftermath of traumatic events, but whose distress is not associated with any substantial level of dysfunction.
- People who are more substantially distressed but are able to function satisfactorily. These are people who have greater distress but not amounting to a mental disorder.

Group 3: ***People who have more sustained or persistent distress associated with dysfunction (two subgroups)***

- People who are likely to recover, but whose recovery takes more time and who may recover relatively quickly if given appropriate assistance.
- People who may be in the course of developing a mental disorder

Group 4: People who develop a mental disorder

- People who require specialist assessment followed by timely and effective mental health care at any point post the Major Emergency.

Caveat: It is worth noting that current theoretical understanding on peoples' responses to Major Emergencies has focused on individual reactions. This poses limitations in generalising to group/population responses. It also risks underestimating the importance of group contexts.

Protective and Risk Factors In Responding to Major Emergencies

PROTECTIVE FACTORS

The primary protective factor consistently recognised in both research and evidence based practice is that of social supports. The availability and utility of social supports buffer the effects of stress and can reduce the prevalence of distress and psychological symptoms, including depression and anxiety. Greater social supports are generally associated with lower stress. People who have good social support networks tend to be better adjusted regardless of disaster exposure. Lack of social support proved to be one of the strongest risk factors for PTSD in Brewin et al's (2000) meta analysis of the literature.

RISK FACTORS

Research has identified a variety of risk factors and many of these risk and vulnerability factors are listed in Table 1.

TABLE1. RISK AND VULNERABILITY FACTORS (ALEXANDER, 2005)

A: Pre-traumatic event factors

- Personal capabilities and attributes
  - Poor attachment capacity
  - Few current attachments
  - Female gender
  - Extremes of age and development (children and older people)
- Past personal experiences
  - Sexual abuse in childhood
  - Substance misuse
  - Previous psychiatric history
  - Disadvantage (social, educational or economic)
- Environment
  - Concurrent life stressors
  - Lower social capital

B: Peri-traumatic event factors

- Nature of incident/disaster
  - Human-made disasters
  - Sudden and unexpected events
  - Exposure to grotesque scenes and sensory experiences
  - Proximity (there is, generally, a dose-response relationship)
  - Nature of involvement (closer involvement increases the risk)
  - Extended exposure (for example, entrapment)
- Impact of the event
  - Higher perceived level of threat to life (self or others)
  - Physical injury
  - Extensive personal loss

C: Post-traumatic event factors

- Response to the event
  - Severe acute stress responses
  - Presence of survivor or performance guilt
- Burden consequent on the event
  - Lack of social and/or family supports
  - Relocation or displacement
  - Financial and social or relationship problem
  - Adverse reactions from others (for example blame or rejection)

2.2 Key Issues in Response

The key issues in responding to the psychosocial and mental health care needs of people affected by Major Emergencies are:

- The overall recovery of individuals can be affected by how their psychosocial reactions are understood and managed. Thus the Health Service recognises the need for, and is committed to working collaboratively with all relevant agencies to ensure, the effective management of the psychosocial response.

- Planning and anticipation are key components in ensuring the effectiveness of psychosocial response in Major Emergency situations.

- Plans for how societies and services are to respond to the psychosocial and mental health needs of populations in the aftermath of traumatic events should recognise the considerable resilience of people and groups of people, including families, communities and groups of strangers, who are thrown together by events.

- Restoring the social functioning of communities, and protecting vulnerable individuals and communities from the psychosocial effects of Major Emergencies, are important components in all aspects of Major Emergency management, as is actively maximising participation of local, affected populations.

- All aspects of psychosocial and mental health care should only be provided with full consideration of people's wider social environments and, particularly, the families and the communities in which they live and work.

- The model of care needs to cater for the different levels of impact on people, while acknowledging the importance of anticipated reactions, resilience and the natural healing potential of people, families and communities. It should also be realistic and flexible, as well as age and culturally appropriate.

- The services designated to provide psychosocial care and meet mental health care needs must be capable of responding to Major Emergencies of different types and various causes. All plans should build upon the existing clinical skills and services available.

- All actions taken must do no further harm.

2.3 Aims and Objectives Following Major Emergencies

AIMS

The aims of providing psychosocial and mental health care in the aftermath of Major Emergencies of all kinds are to:

- Mitigate the psychosocial and mental health effects on people by responding proportionately, flexibly and in a timely way to the phased needs of people who are affected; and

- Ensure a continuum of care, provided in an integrated way that recognises that people's needs may be immediate, as well as short, medium or long term.

OBJECTIVES

The key objectives of psychosocial and mental health service responses to Major Emergencies should be:

- Integrating psychosocial and mental health care responses to individual and communities' needs within the Major Emergency strategic and operational planning and response processes;
- Providing specialist input to the management of the response;
- Empowering communities and people in their self care;
- Attending first to the basic needs of the populations that are affected;
- Developing and enacting effective communication and advisory plans that involve the public and the media, including social 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.
- Ensuring that the staff of all organisations involved in the psychosocial response to a Major Emergency are well managed, supervised and supported; and
- Promoting learning by planning and managing knowledge acquisition and its transfer, by constant evaluation and by effective performance management.

2.4 The Psychosocial Footprint

Figure 2: *Diagrammatic Representation of Psychosocial and Medical "Footprints"*

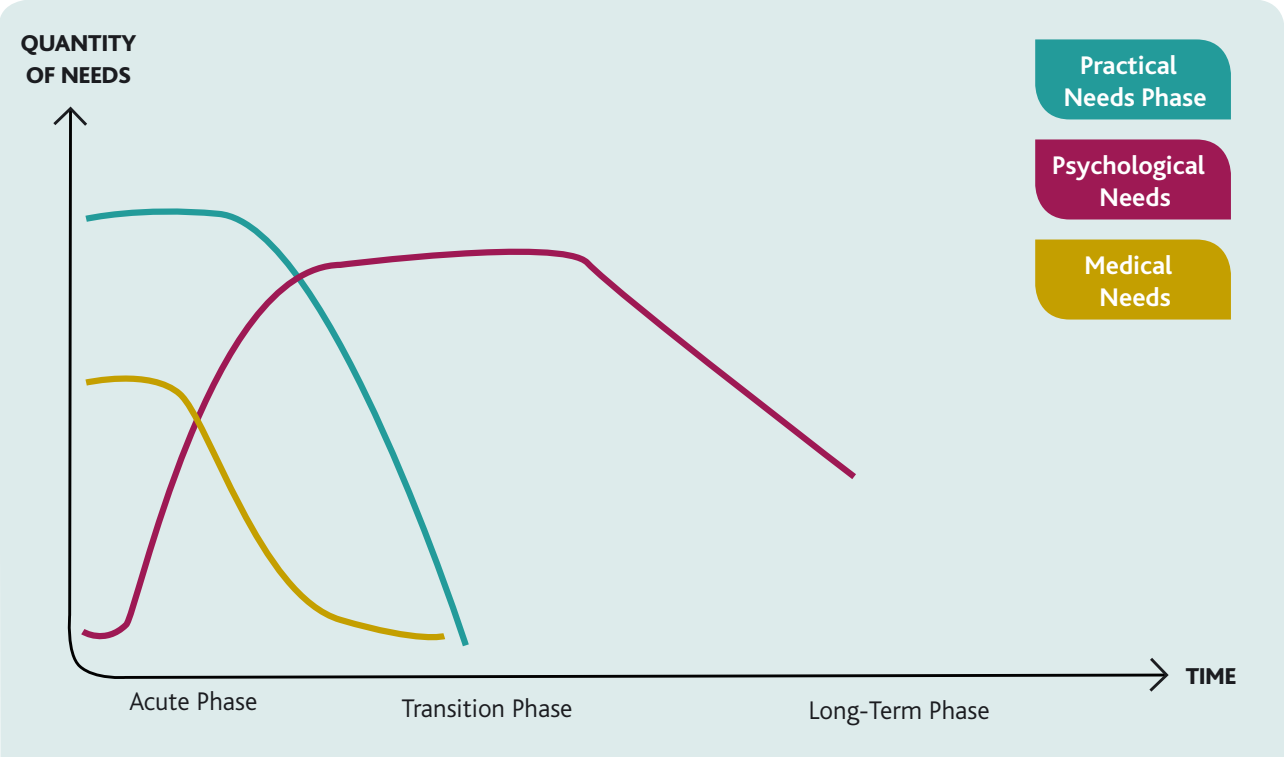
The Psychosocial "Footprint" of a Major Emergency is generally larger than the medical "Footprint" (Shultz et al., 2006) because of

- The greater number of individuals impacted, and
- The greater social, community and environmental impact.

The Psychosocial impact of a Major Emergency affects not only the injured but also responders, helpers, witnesses to the event, friends and relatives of those affected, and those uninjured but involved, and, in parallel with this increase in the numbers affected, it is important to note that the time required to address the resulting psychosocial needs may be much longer than the time spent on the medical treatment of the injured.

Figure 3 below gives a general graphical representation of the evolution of the needs of survivors following Major Emergencies. The graph illustrates how the medical, psychological and practical needs of those affected change over time.

***Figure 3**: The Needs of Survivors Following a Major Emergency*



NEEDS	APPROPRIATE RESPONSE*
Medical Needs:	Treatment of physical injuries; medium and longer-term rehabilitation
Psychological Needs:	Psychosocial support; medium and longer-term Psychological/Mental Health support, as appropriate
Practical Needs:	Shelter, Refreshments, Information, Clothing, Contact with Family, Financial Support, Re-housing, etc, as required

* Varies with incident type and characteristics of the individual involved but could include some or all of these elements.

2.5 Psychosocial Interventions and Principles

The area of practice in post-disaster psychosocial intervention has not received the same evidence based focus as other areas of intervention. There is a debate ongoing regarding issues such as - the timing of early psychosocial interventions, who can provide them, what form they should take and any follow-up that may be involved. The gap in the field has led to a search for an evidence informed framework for post-disaster psychosocial intervention. What is described throughout this section is the consensus of current thinking in the area, which includes the key principles and elements of practice that inform the design and delivery of the psychosocial response.

FIVE KEY PRINCIPLES

Hobfoll et al. (2007) from their systematic review identified five principles and devised guidelines for the development of intervention practices and programmes in the aftermath of emergencies and mass violence. The principles are:

- Promote a Sense of Safety,
- Promote a Sense of Calming,
- Promote a Sense of Self-Efficacy and Collective Efficacy,
- Promote Connectedness
- Promote Hope.

The authors of other key documents, such as the Guidance for Responding to the Psychosocial and Mental Health Needs of People Affected by Disasters or Major Incidents (NATO/TENTS 2008), have accepted the validity of these principles and explicitly recommend that all service responses should be based on these principles.

PSYCHO-EDUCATION

To quote Hobfoll et al, "Psycho-education serves to normalise reactions and to help individuals see their reactions as understandable and expected. Normalising and validating expectable and intense emotional states and promoting survivors' capacities to tolerate and regulate them are important intervention goals at all levels."

Psycho-education, regarding normalising responses, forms part of the public health intervention post a Major Emergency and can include:

- Education about the current situation
- Explanation of specific phenomena in the victims' traumatic experience
- Strengthening self-help
- Limitations of self-help- signposting to more appropriate services as defined by need.

EUTOPA, (2008)

PRACTICAL HELP AND PRAGMATIC SUPPORT

Appropriate responses include 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.

SOCIAL SUPPORT FOR FAMILIES AND SOCIAL GROUPINGS;

Social support can include;

- 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.
- Involving relevant community organisations in supporting psychosocial and mental health care responses.
- Identifying the most appropriate supportive resources (e.g. families, communities, schools, churches and friends).

TENTS INTERVENTIONS

The TENTS Project (European Network for Traumatic Stress (2007-2009) Team has produced a booklet 'Interventions in the Aftermath of Disaster' that includes a range of interventions and other evidence based recommendations, (e.g. NCCMH, 2005), including pharmacological treatment for adults with PTSD, and interventions for traumatised children and adolescents. The TENTS Project documentation provides recommendations on components of a response in varying time frames such as Within the First Week, First Month, One to Three Months, and beyond Three Months. This can be accessed at www.tentsproject.eu.

2.6 Psychological First Aid

Psychological First Aid (PFA) is viewed as an evidence-informed approach (not a single intervention or treatment). PFA is designed to reduce the initial distress caused by traumatic events and to foster short-term and long-term adaptive functioning and coping. It does not assume that all survivors develop mental health problems, more serious health difficulties or long-term difficulties in recovery.

The principles and techniques of PFA meet four basic standards:

- consistent with research evidence on risk and resilience following trauma;
- applicable and practical in field settings;
- appropriate for developmental levels across the lifespan; and
- culturally informed and delivered in a flexible manner.

Table 2 *– Objectives of Psychological First Aid*
From The Manual of the National Child Traumatic Stress Network (2006)

OBJECTIVES OF PFA	THUS, THE KEY EFFECTS OF PFA ARE
• Establish a human connection in a non-intrusive, compassionate manner; • Enhance immediate and ongoing safety, and provide physical and emotional comfort • Calm and orientate emotionally overwhelmed or distraught survivors; • Help survivors to tell others specifically about their immediate needs and concerns and gather information as appropriate; • Offer practical assistance and information to help survivors to address their immediate needs and concerns; • Connect survivors as soon as possible to social support networks including family members, friends, neighbours and community resources; • Support adaptive coping, acknowledge coping efforts and strengths, and empower survivors; • Encourage adults, children and families to take an active role in their recovery; • Provide information that may help survivors to cope effectively with the psychosocial impacts of disasters; and • Be clear about the availability of responders who are able to help and, when appropriate, link survivors with disaster response teams, local recovery systems, mental healthcare services, other public-sector services and other relevant organisations.	• Providing comfort and consolation; • Protecting people from further threat and distress; • Providing immediate physical care; • Encouraging goal orientated and purposeful behaviour; • Helping people to reunite with loved ones; • Enabling voluntary sharing of experiences; • Linking survivors with sources of support; • Facilitating a sense of being in control; and • Identifying people who need further help (triage).

IDENTIFYING PEOPLE AT RISK

Formal screening of everyone affected need not be conducted, as current screening measures have low predictive value. Responders need to be aware of the importance of identifying as early as possible those people who are at risk or have active symptoms. Refer to Table 1.

THE KEY ROLE OF GENERAL PRACTITIONERS

General Practitioners **play a central role** in psychosocial responses. General Practitioners need to be made aware of possible psychosocial experiences and psychopathological sequelae because they are directly involved in delivering the first level of formal mental health care.

SPECIALIST INTERVENTIONS

Specialist interventions need to be evidenced based. For example, trauma focused cognitive behavioural therapy/eye movement desensitisation and reprocessing (EMDR) are generally provided by Level 3 and 4 services. All interventions delivered need to be in keeping with best practice professional guidelines as exemplified by the National Institute of Health and Care Excellence (NICE).

DEBRIEFING

Debriefing as a formal structured intervention of eliciting the facts, thoughts, feelings, emotional responses and normalising the reactions, etc., is not recommended. The NICE Guidelines for PTSD (2005) states that one-off debriefings that focus on people's emotional experiences are contra-indicated. TENTS (2008), NATO (2009), Primary Care Standing Committee (IASC) (2007) and others have advised that single session individual psychological debriefing for individuals affected should not be provided.

SECTION 3

THE STRATEGIC STEPPED MODEL OF CARE

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SECTION 3: THE STRATEGIC STEPPED MODEL OF CARE

3.1 Introduction

The core components of the Strategic Stepped Model of Care are illustrated here in Figure 4.

***Figure 4**: The Strategic Stepped Model of Care - Williams R & Kemp V, 2008*

The Strategic Stepped Model of Care is evidence informed by key contributors in psychosocial research and practice. Primarily, the model is intended to be a tool for planners and managers rather than clinicians, because effective responses to each person's needs require the seamless integration of services.

The Strategic Stepped Model of Care is divided into:

Preparedness - Pre-Event

1. Strategic Planning, and
2. Prevention Through Developing Resilience

Response - Post-Event

Levels 1 to 4 that outline the nature and type of service offered in the aftermath of Major Emergencies

3.2 Preparedness – Pre-Event

1. **Strategic Planning:** This refers to comprehensive multi-agency planning, preparation, training and exercising of the full range of service responses that may be required during and in the aftermath of a Major Emergency. Adequate preparation for psychosocial response requires the preparation of local Psychosocial Response Plans and the inclusion of a psychosocial response element in the development and exercising of all Health Service Major Emergency plans. Strategic preparedness supports psychosocial resilience and is, therefore, likely to improve responses and reduce the risk of negative outcomes, including severe distress and mental disorder.

2. **Prevention Through Developing Resilience**: This refers to services that are delivered in advance of adverse events and which are orientated towards supporting the collective resilience of individuals and communities. The Health Service routinely, through its various departments (e.g. Public Health, Mental Health and Primary Care), engages in activities and programmes designed to develop and support the cohesion, resourcefulness, mental wellbeing and resilience of individuals and communities. This work is a key aspect of prevention, in mitigating the inherent and consequential stressors that are produced by Major Emergencies and, thereby, reducing the impacts of events on individuals, families and communities. The psychosocial responses provided in the aftermath of an event are guided by a recognition of the important role in the recovery process of sustaining people's resilience and of assisting them in their recovery.

3.3 Response – Post-Event

In general terms, the needs of people who have been involved in a Major Emergency become greater and potentially more complex as one moves through the four response levels, while the numbers of people involved decreases (see Table 3). Accordingly, there is a progression in the level of expertise required to deliver responses which follows the rising levels. However, the levels of service delivery described are neither categorical nor sequential, but rather represent a continuum that promotes seamless care for the people who require it. Thus, for example, an individual presenting with significant mental health difficulties in the immediate aftermath of their involvement in a Major Emergency would appropriately access Level 3 and 4 services whilst continuing to require the level of psychosocial support from Level 1 service provision.

Level 1 Services: This refers to the provision of empathic, practical and pragmatic support for everyone who requires it in the aftermath of a Major Emergency. This support is delivered by frontline response services, including the Principal Emergency Services, the voluntary emergency services and hospitals, as well as community organisations, churches and schools, supplemented by families and friends. As per the Framework, the frontline response services will attend to the initial needs and distress of casualties and survivors and this role requires that they have an awareness of the psychosocial impact of events on both individuals and communities.

The Health Service Psychosocial Management Team (HSPMT) will provide appropriate advice and support to these efforts based on the principles of Psychological First Aid. This could involve:

- Making contact with the response services (Gardai, Civil Defence, etc.) at all facilities (Survivor Reception Centres, Rest Centres, Hospitals, Mortuaries, etc.) where Survivors/Casualties/Evacuees/Families are or will be located
- Providing support to these services in the form of written resources, advice, etc.
- Sending appropriate staff to these locations, as required and as they become available, to provide advice and support, as well as providing effective communications between these locations and the Health Service Psychosocial Management Team.

Level 2 Services: This refers to provision of services, based on the principals of Psychological First Aid, delivered by approved psychosocial responders (approval is by the Health Service Psychosocial Management Team) who are supported by the staff of specialised Psychological and Mental Health Services. It is envisaged that these psychosocial responders could be drawn from the health services, the Child and Family Agency and/or recognised funded organisations in the social care area.

Level 3 Services: This refers to the provision of screening, assessment and intervention services as appropriate for people who do not recover from immediate and/or short-term distress. These are provided by Health Service Primary Care professionals and GPs, to whom advisory, consultation and support services are provided by staff of specialist Psychological and Mental Health Services as well as from the Child and Family Agency.

Level 4 Services: Services at this level are targeted at those individuals who continue to exhibit significant distress and/or mental health difficulties following the event and are provided by Psychological and Mental Health Services as well as by the Child and Family Agency.

Table 3 on the next page illustrates the four different levels of response in terms of the problems involved, the nature of the service provided, the persons providing the service and hypothetical time scales.

It is important to note that, where the different levels are presented against hypothetical time scales, these time scales are not hard and fast but, rather, indicative. They are intended to offer a framework for illustrative and comparison purposes which is intended to facilitate the work of those involved in planning, training, and service development. In the case of individual events, they should be interpreted in the light of what is known about the nature of the event, the people who are available to respond and the needs of the individuals who are affected

Table 3: *Service Delivery in the Strategic Stepped Model of Care*

	NATURE OF PROBLEMS	NATURE OF SERVICE	PERSONS PROVIDING SERVICE	HYPOTHETICAL TIME SCALE* DAYS POST INCIDENT
Level 1	Transient and short-term distress *Resistant and resilient people*	Providing empathic, practical and pragmatic support for everyone who requires it	Frontline Response Services, including PESs, voluntary emergency services and hospitals, as well as community organisations, churches and schools, supplemented by families and friends.	0-14
Level 2	Medium-term distress *Resilient people*	As above, with the additional practice informed by the principles of Psychological First Aid	Approved psychosocial responders with professional support	1-30
Level 3	Longer-term distress *People with sustained or persistent distress associated with dysfunction*	Primary health care: mental health/psychological assessment and access to psychological therapies	Primary Care teams working with staff of Community Mental Health Services, Psychological Services and/or Child and Family Agency	28-365 Can be before 28 days if extreme.
Level 4	Mental health difficulties *People with mental health difficulties*	Specialist mental health/ psychological assessment and access to the range of mental health/psychological interventions	Specialist Mental Health Services. Staff of Community Mental Health Teams, Psychological Services and/or Child and Family Agency	28 and continuing

**This hypothetical time scale is provided for illustrative and comparison purposes only. It represents a possible sequence of days over which the relevant services could be provided during the aftermath of a single violent incident. It is acknowledged that other circumstances could result in a different configuration of days.*

SECTION 4

PRE & POST EVENT ROLES AND TASKS

A Vision for Change
ADVANCING MENTAL HEALTH IN IRELAND

SECTION 4: PRE & POST EVENT ROLES AND TASKS

4.1 Background

The Health Service has primary responsibility for the provision of psychosocial support to members of the public who may be affected by a Major Emergency. A key principle that informs this Guidance Document is that all care providers and agencies involved in responding have some responsibility for the psychosocial care needs of affected individuals and communities. This section needs to be read in conjunction with the Framework for Major Emergency Management, Appendix F5 (Functions of the Principal Response Agencies), available on www.mem.ie, which sets out the particular roles and responsibilities of the Health Service and the other Principal Response Agencies in preparing for and contributing to an inter-agency response to Major Emergencies.

No two Major Emergencies are the same. There are multiple factors at play, e.g. the numbers of people affected, the severity of the incident, spatial and demographic considerations, etc. Hence response plans need to be adaptive, as there are a variety of decisions that will need to be made at the time of the incident, based on the unique circumstances involved and the evolving information. As the Strategic Stepped Model of Care demonstrates, the needs of individuals and communities change as time goes on and therefore the response needs to adapt. The lists of operational process and tasks included here are not intended to be prescriptive or exhaustive. They are intended to provide the user with prompts in order to encourage consideration of the various aspects of psychosocial provision, when planning a local response. Each response will, of course, also need to be proportionate to the event/emergency involved.

Major Emergencies require a multi-agency response, where flexibility, partnership and information sharing are required to deliver the most appropriate and effective response. Hence, there is a requirement for all relevant agencies to engage in multi-agency collaboration and cooperation so as to ensure:-

On Planning: that plans are well-integrated, responsive, and provide predictable services;
On Delivery: that explicit inter-agency agreements are in place that identify the actions of each agency and ensure effective coordination; and
On Review: that regular inter-agency reviews are conducted of the efficiency and effectiveness of individual and shared plans and joint response arrangements.

4.2 Preparedness

As with other areas of Major Emergency provision, effective preparedness for psychosocial care requires comprehensive multi-agency planning, preparation, training and exercising of the full range of service responses that may be required. The role of the Health Service needs to fit seamlessly within such a multi-agency framework.

NATIONALLY, THE HEALTH SERVICE WILL:

- Develop a comprehensive implementation plan to support this Guidance Document
- Identify the external agencies whose assistance is required to deliver effective psychosocial support, during and in the aftermath of Major Emergencies, such as the Child and Family Agency, the National Educational Psychological Service (NEPS), the Principal Emergency Services, the Civil Defence Service, the Red Cross, etc.
- Engage with the MEM National Working Group and key non-health agencies on the organisation and delivery of effective inter-agency psychosocial support.
- Enhance Service Level Agreements with funded agencies in the social care area in order to ensure psychosocial responses are provided to agreed standards.
- Develop relevant educational material for Health Service staff and others to fulfil their role in delivering the Strategic Stepped Model of Care.
- Recommend to each Area Health Service Manager that they designate the relevant Principal Psychology Manager(s) within their area to take primary responsibility for delivering an effective health service/inter-agency response to the psychosocial and mental health care needs of populations affected in Major Emergencies.
- Embed psychosocial responses to Major Emergencies within existing health service communications policy and infrastructure (help lines, websites and social media).
- Ensure media training for relevant health service personnel.
- Nominate a panel of experts in the area of psychosocial care to be available to advise National Health Service Management as required.
- Engage in and support well designed research and evaluation in the area of psychosocial provision in Major Emergencies.
- Ensure that this guidance is kept up to date with the advancement of scientific knowledge and experience in the field of psychosocial response to Major Emergencies

NATIONALLY, THE HEALTH SERVICE AND THE IDENTIFIED HEALTH AND EXTERNAL AGENCIES WILL:

- Agree their respective roles and responsibilities in the delivery of an effective psychosocial response to a Major Emergency.
- Agree a process for the planning, preparation, awareness raising/training and response to the psychosocial aspects of Major Emergencies.
- Ensure that each agency will prepare its own internal procedures to address the agreed processes and will undertake appropriate awareness raising/training of relevant staff.
- Develop quality assured resources and information materials for the public that will allow for local adaptation to a specific emergency event.

REGIONALLY, THE HEALTH SERVICE WILL:

Implement the recommendations of this Guidance Document and instruct the appropriate managers accordingly, through the Regional Management structure.

LOCALLY, THE HEALTH SERVICE WILL:

- Through the Area Manager, assign responsibility to the Principal Psychology Manager to lead the local psychosocial response to Major Emergencies. In relation to this additional function, the Principal Psychology Manager's line management responsibility will be to the senior area manager (i.e. SA Manager in line with organisational structures).
- Nominate the Principal Psychology Manager to be a member of the Community Health Services Co-ordinating Group.
- Ensure that appropriate Health Service staff have the necessary awareness, training and competencies required to fulfil their role in delivering the Strategic Stepped Model of Care.
- Provide timely access to its own Primary Care, Psychological and Mental Health Services or through Service Level Arrangements to voluntary organisations providing similar services.

THE PRINCIPAL PSYCHOLOGY MANAGER WILL:

- Take primary responsibility for ensuring that the necessary mechanisms and processes are in place to deliver an appropriate and effective health service and inter-agency response to the psychosocial and mental health care needs of populations affected by Major Emergencies.
- Establish and chair a Health Service Psychosocial Management Team (HSPMT). The functions and composition of this grouping are set out below.
- Establish and chair a Partner Agencies Psychosocial Group (PAPG) which will, as far as possible, be representative of the local configuration of mental health care and psychosocial services.
- Specify in consultation with the Community Health Services Co-ordinating Group, the Health Service Psychosocial Management Team and the Partner Agencies Psychosocial Group, the nature, scope and scale of the psychosocial response during and in the aftermath of each Major Emergency.

4.3 Local Structures

HEALTH SERVICE PSYCHOSOCIAL MANAGEMENT TEAM (HSPMT)

The function of this team is to support the planning, coordination and management of the psychosocial response (Strategic Planning and Service Delivery) before, during and after a Major Emergency.

As well as the Principal Psychology Manager, the group could appropriately include, among others, representatives at senior grades from Mental Health, Social Work, the Child and Family Agency, Area Management, Psychology, Nursing, Emergency Management and Communications. Locally this group could include, or liaise with, the acute hospital(s).

Tasks of the HSPMT will include the following:

IN PREPAREDNESS

- Preparation of local Psychosocial Response Plan.
- Completion of a network analysis of local psychosocial services and incorporation of them, where relevant, into the local Psychosocial Response Plan.
- Enhancement of relevant Service Level Agreements, where appropriate, with local agencies in the social care area in respect of their roles in response.
- Liaison with all relevant local external (principally non-health) agencies in respect of their roles in Level 1 service delivery.
- Development and putting in place of local plans, structures, processes and arrangements which will assist in the provision of an integrated psychosocial response system for Major Emergencies.
- Assurance that appropriately trained Health Service personnel are available to deliver on key response roles in the Strategic Stepped Model of Care, e.g. provide, when required, expert advice to Frontline Response Services, including voluntary emergency services and hospitals (Level 1), Community and Family Services (Level 2), and Primary Care Teams (Level 3).
- The making of provision for scalable, flexible and adaptable operational capabilities, since it is not possible to anticipate the nature, scale and location of Major Emergencies.
- Liaison with local acute hospital(s) in terms of the provision of care, collation of data, etc.
- Approval of "local psychosocial responders" as appropriate.
- Arrangements for Public Communication and dealing with the Media that are in keeping with Health Service practice and procedures for Major Emergencies. Liaison with Health Service Communications function.
- Implementation of systems to support data recording (with appropriate regard for patient confidentiality) on the overall psychosocial response.
- Integration of the local Psychosocial Response Plan into the Health Service Regional Major Emergency Plan.
- Integration of psychosocial response into relevant Major Emergency training and exercises.
- Implementation of good clinical practice in all of the above.
- Development of strategies and procedures for dealing with predictable issues, such as 'volunteers' who claim competencies in this area which are not pre-validated.

IN RESPONSE

- Activation of appropriate plans and resources.
- Provision of effective leadership and management.
- Monitoring and quality assuring all aspects of the psychosocial response.
- Preparing reports on the psychosocial response for the Health Service Crisis Management Team, as required.
- Continuing strategic review/planning throughout each incident and afterwards (e.g. through the recovery stage) since all plans, no matter how comprehensive, will require adjustment and further development as each event and the response to it is reviewed.

PARTNER AGENCIES PSYCHOSOCIAL GROUP (PAPG)

The composition of this group will, as far as possible, be representative of the local configuration of mental health care and psychosocial services. The function of this group will be to agree the relevant elements of the Psychosocial Response Plan, including preparedness, exercising and delivery.

Relevant Tasks will include the following:

- Develop an inter-agency plan for responding to emergencies that includes:-
  - Respective roles
  - Mobilisation and Implementation procedures
  - Coordination
  - Information Sharing
  - Agreed arrangements for the temporary working relationships of staff from other organisations deployed to assist the Health Service in the aftermath of a Major Emergency.
- Conduct training and exercises to ensure preparedness
- Review the Response Plan regularly.

4.4 Resilience

Resilience Building is regarded as 'everyone's business' and many statutory organisations, together with community organisations, have key roles to play in developing and sustaining resilience.

The Health Service, in its ongoing role through its various services, for example, Health Promotion and Public Health, engages in activities and programmes which directly and/or indirectly contribute to the psychosocial resilience and mental well-being of individuals, families, local communities, schools and workplaces. This work is a key aspect of prevention, in mitigating the inherent and consequential stressors that are produced by Major Emergencies and, thereby, reducing the impact of these events on individuals, families, communities and vulnerable people.

Effective planning and co-ordination of service responses to Major Emergencies can maximise the collective resilience of the public and communities as well as the personal resilience of people affected by Major Emergencies.

4.5 Service Delivery Level 1

Frontline response services, including the Principal Emergency Services, the voluntary emergency services and hospitals, as well as community organisations, churches and schools, supplemented by families and friends, can provide empathic, practical and pragmatic support for everyone who requires it in the aftermath of a Major Emergency. As per the Framework, the frontline response services attend to the initial needs and distress of casualties and survivors and this role requires that they have an awareness of the psychosocial impact of events on both individuals and communities. The Health Service Psychosocial Management Team will provide appropriate advice and support to these efforts, based on the principles of Psychological First Aid.

PROCEDURAL BRIEFING NOTES: IMMEDIATE PHASE – 24 HOURS

It can be assumed that a variety of assistance will be offered to affected persons in the first few hours after an incident, before the Health Service Psychosocial Management Team has been deployed.

The Injured: Those injured in the incident will be triaged and brought to receiving hospitals where psychosocial support will be provided as appropriate.

Survivors and Evacuees: Survivor Reception Centres and Rest Centres are secure locations to which survivors and/or evacuees, not requiring hospital treatment, can be taken for shelter, first aid, interview and documentation. Provision should be made at these centres for the immediate physical and psychosocial needs of survivors, such as information, hot drinks, food, blankets, telephones, first aid for minor injuries, etc.

Families: Depending on the nature of the event, a Friends and Relatives Reception Centre may be established at or near the incident site, in a hospital, or at a mortuary, and family members and friends will be directed there. The purpose of such a centre is to provide a comfortable area where the family and friends of those involved in the incident (primarily the family and friends of Casualties and Survivors) can be directed for support and information.

It is the responsibility of the Local Authority to establish and run Survivors Reception Centres, Rest Centres and Friends and Relatives Reception Centres and decisions about whether to establish any such centre will be made by An Garda Síochána and the Local Authority

Included in Appendix 3 is a scenario which illustrates much of the above information

OPERATIONAL PROCESSES AND TASKS

- Activate alerting procedures for the Health Service Psychosocial Management Team and, where appropriate, relevant members of the Partner Agencies Psychosocial Group.
- Activate the Psychosocial Response Plan.
- Activate key capabilities, e.g. approved psychosocial responders, information resources, support to Survivors/ Friends and Relatives/Rest Centres, website, etc.
- Principal Psychology Manager, or alternate, to consult with key players to determine, with the Health Service Psychosocial Management Team and, where appropriate, members of the Partner Agencies Psychosocial Group, the appropriate nature, scope and scale of the required psychosocial response.
- Collect and assess information on places where Survivors/Casualties/Evacuees/Families are or will be located and identify staff to go to these and other relevant locations, as required.

- Prepare a plan of action for the specific event.
- Deploy key capabilities, e.g. approved psychosocial responders, to relevant locations.
- Ensure effective mechanisms are in place for the sharing of information.
- Conduct meetings and briefings, as required, during the course of the response. Note: the timings of meetings need to take into account the times of Health Service Crisis Management Team meetings, so that information can be fed upwards.
- Coordinate the inter-agency aspects of the psychosocial response with key external agencies.
- Activate pre-planned communication systems and ensure they are in place and effective.
- Consider triggering, or putting on standby, psychosocial response(s) in distal location(s).
- Consider activation of phone information/help lines – including issues such as type, purpose, delivered by whom and timeline.
- Maintain and distribute records of decisions and action points.
- Provide specialised psychosocial advice, where required, to Health Service managers, inter-agency managers and Frontline Response Services.
- Provide specialist advice to community, family, and educational services, as needed.
- Ensure an adequate provision of psycho-educational information (via, for example, written resources, websites and media, including social media) and consider appropriate locations/agents for its distribution e.g. Principal Emergency Services, voluntary emergency services and hospitals, GPs, churches and community venues.
- Utilise Health Service websites and the media, including social media, as appropriate, to normalise reactions.
- Monitor performance and intervene to bolster the response where necessary.
- Initiate consultation with communities and individuals, to ensure the response is effective.
- Ensure that effective pathways of support exist and that information on same is available to people affected.
- Make General Practitioners and relevant health workers aware of possible psychosocial needs and mental health sequelae, because they will be directly involved in delivering the first level of formal mental health care.
- Prepare reports for Area Managers/General Manager, as required.

4.6 Service Delivery Level 2

Approved psychosocial responders, who are supported by the staff of specialised Psychological and Mental Health Services, provide responses to the psychosocial needs of individuals and communities that are based on the principles of Psychological First Aid.

OPERATIONAL PROCESSES AND TASKS

- Continue implementation, coordination and review and of the Psychosocial Response Plan.
- Ensure appropriate support, where approved psychosocial responders are integrated into the response plan.
- Implement appropriate rotation policies and supervision, as part of staff welfare, i.e. stand down and replace key staff before "burn out" becomes an issue.
- Ensure there are clear, workable arrangements in place which will allow for prompt access to appropriate services by individuals who require a higher level of support.
- Continue provision of information resources to GPs, Public Health and Community Health teams.
- Ensure that psychosocial informational materials are integrated with the internal Health Service and overall inter-agency aspects of the psychosocial response.
- Continue to identify the agencies and service providers in the community to whom those affected may turn in order to find support, such as youth clubs.
- Consult with the identified agencies and educate them re phases of recovery, assist them in identifying 'at risk' and 'hard to reach' groups and ensure that the pathways to additional support and formal care are understood.
- Collate information as per agreed standards, such as numbers being provided with care.
- Consider psychosocial needs of bereaved families and friends, ensuring cultural appropriateness.

4.7 Service Delivery Level 3

Appropriate staff attached to Primary Care Teams or Networks providing assessment and intervention services for people who do not recover from immediate and short-term distress.

OPERATIONAL PROCESSES AND TASKS

- Provide timely assessment and intervention services for people who do not recover from immediate and short-term distress. These are provided by Health Service Primary Care professionals and GPs, to whom advisory, consultation and support services are provided by staff of specialist Psychological and Mental Health Services.
- Provide timely access to specialist Psychological and Mental Health assessments, intervention and management where it is required.
- Ensure staff with the required skills and expertise are available from Psychological and Mental Health Services to provide advice to staff in Primary Care in order to augment primary healthcare responses.
- Ensure ongoing support to approved psychosocial responders.
- Continue to consult/engage with individuals and groups in the community re recovery and resilience building.
- Monitor and review Public Information Campaign – Website, Help Line, Newsletters, Leaflets, Press Releases, Radio, TV, Social Media
- Provide evidence based interventions as identified by professional and national bodies/NICE guidelines.

4.8 Service Delivery Level 4

The core role of the Health Service at Level 4 is to provide timely, appropriate and responsive Psychological and Mental Health Services for people who have developed, or are thought to have developed, mental health difficulties that require specialist intervention as a consequence of the Major Emergency. These individuals may require medium and/or long-term mental health care. Predominantly the services at this level are provided by the Health Service but they may be augmented in certain parts of the country by other organisations with similar expertise.

OPERATIONAL PROCESSES AND TASKS

- Provide evidence based interventions, as identified by professional and national bodies/ NICE guidelines.
- Raise awareness re 'Anniversary Effects' using Public Information systems, e.g. Website, Newsletters, Leaflets, Press Releases, and through inter-agency working.
- Psychological and Mental Health Services staff providing assessment and intervention to those individuals who continue to exhibit significant distress and/or mental health difficulties following the event.

SECTION 5

CONCLUSION and Appendices

A Vision for Change
ADVANCING MENTAL HEALTH IN IRELAND

SECTION 5: CONCLUSION

It is expected that this document will provide guidance and assist local Health Service areas in preparing effective responses to the psychosocial and mental health consequences for survivors and the public following Major Emergencies. It is informed by current evidence, theory and practice. This document provides key insights into the psychosocial roadmap and guidance in regard to roles, responsibilities, operational processes and procedures to manage the response a Major Emergency in a co-ordinated and collaborative manner. It is not intended to be prescriptive as no two Health Service Areas are identical and available services vary from area to area.

It is expected that each Health Service Area will develop its own Psychosocial Response Plan, as part of the Major Emergency planning process, in conjunction with local services and organisations, using this guidance document. Ideally plans should be exercised and audited on an annual basis (see Appendix 4).

Appendix 3 provides an example of a possible Major Emergency where this guidance could be implemented

Practitioners need to be aware that this guidance document should be implemented in the context of the wider Major Emergency Management Framework and its associated structures and documentation, see www.mem.ie.

Appendix 1 - Bibliography and Web Links

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Web Links

TEXT SPECIFIC

www.mem.ie

www.coe.int/t/dg4/majorhazards/ressources/virtuallibrary/materials/Others/NATO_Guidance_Psychosocial_Care_for_People_Affected_by_Disasters_and_Major_Incidents.pdf

www.tentsproject.eu

http://www.eutopa-info.eu/index.php?id=69

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MENTAL HEALTH - IRELAND

www.hse.ie/eng/services/Publications/services/Mentalhealth/Mental_Health_-_A_Vision_for_Change.pdf

www.hse.ie/eng/services/Publications/services/Mentalhealth/Advancing_the_Shared_Care_Approach_between_Primary_Care_Specialist_Mental_Health_Services.pdf

Appendix 2 - Key Major Emergency Terms

Principal Response Agencies: The agencies designated by the Government to respond to Major Emergencies, i.e. An Garda Síochána, the Health Service Executive and the Local Authorities.

Principal Emergency Services: The services which respond to emergencies in Ireland, namely An Garda Síochána, the National Ambulance Service, the Fire Service and the Irish Coast Guard.

Major Emergency Plan: Each Principal Response Agency (Garda Division, Health Service Region or Local Authority) has its own Major Emergency Plan, based on the Framework guidance, which sets out its arrangements to respond to any event occurring in, or impacting on, its functional area which requires the Declaration of a Major Emergency

Controller of Operations: The person given authority by a Principal Response Agency to control all elements of its activities at and about the site of a Major Emergency.

Lead Agency: The Principal Response Agency that is assigned the responsibility and mandate for the coordination of activities at site and local levels during the response to a particular Major Emergency.

On-Site Co-ordinator: The Controller of Operations of the Lead Agency who has responsibility for the coordination of activities at the site of a Major Emergency.

On-Site Co-ordination Group: A Group which meets at the site of a Major Emergency and includes the On-Site Co-ordinator and the Controllers of Operations of the other two agencies, an Information Management Officer, a Media Liaison Officer and others as appropriate.

Local Co-ordination Group: A group of senior representatives from the three Principal Response Agencies whose function is to facilitate strategic level co-ordination, make policy decisions, liaise with regional/national level coordination centres, if appropriate, and facilitate the distribution of information to the media and the public.

Health Service Crisis Management Team: A strategic level management group, which consists of senior health service managers, which is assembled to manage a crisis and deal with issues arising, both during the emergency and the subsequent recovery phase.

Rest Centre: Premises where persons evacuated during an emergency (e.g., flooding of their homes) are provided with appropriate welfare and shelter

Friends and Relatives Reception Centre: A secure area, operated by An Garda Síochána, for the use of friends and relatives near the site of a Major Emergency.

Survivor Reception Centre: A secure location to which survivors, not requiring hospital treatment, can be taken for shelter, first aid, interview and documentation. It is the responsibility of the Local Authority to establish and run this centre.

Appendix 3 - Major Emergency Scenario

Below is a generic Major Emergency scenario which illustrates some of the many variables that can emerge during the response to a Major Emergency. It is included in this Guide in order to illustrate to users the considerations and potential actions which can arise in the provision of psychosocial support in the first 24 hours after a Major Emergency. It can be used by local Health Service Psychosocial Management Teams, in conjunction with the guidance in this document, to help inform the creation of their Psychosocial Response Plans and can also be used as a tool in training and exercises.

At 3.05pm on a bright Tuesday afternoon, as noisy groups of children leave Ballybeg National School (280 pupils, 16 teachers, 6 special needs assistants, a caretaker and a secretary, serving the town of the same name, population approximately 1500), there are between 35 and 40 parents outside, some sitting in their cars, others talking in groups, as they wait to collect their children.

At 3.08pm the attention of some of these parents is drawn to an approaching articulated truck, which appears to be travelling very fast. To their horror, they realise, too late, that the truck is out of control and watch as it sideswipes a number of cars and crashes into the wall in front of the school, where a number of children and adults are knocked to the ground. In an instant, a scene of great normality, full of children's laughter, is converted into one of total chaos, with dead, injured, shocked and bewildered adults and children. Parents and school staff rush to help the injured and comfort the dying and, with their bare hands, some try, unsuccessfully, to extract trapped children from under the truck. Parents, staff, children and passing motorists all make 999 calls to the emergency services.

At 3.14pm the first Garda car arrives on the scene and this is followed quickly by more Garda cars, fire engines and ambulances. At the same time the Regional Hospital (twenty miles away in Ballymoor) is notified of the event by the Ambulance Service and prepares to receive casualties.

At 3.24pm the Local Authority declares a Major Emergency and a full inter-agency response is activated.

At 3.26pm local radio interrupts its afternoon music programme with a newsflash on the accident and by 3.30pm a reporter is talking live, by mobile phone, to an eyewitness at the scene. By that stage, word of the accident has spread to all parts of the county, through telephone calls and text messages.

At 3.27pm a text alert is issued to all members of the Health Service Regional Crisis Management Team (CMT) notifying them of the Major Emergency and a teleconference in ten minutes. At this first teleconference (at 3.37pm) initial details of the incident are provided by the Ambulance Service to representatives of the Acute Hospitals, the Community Health Services, the Public Health Service, the Communications Service and Emergency Management.

At 3.39pm officers of An Garda Síochána, the Fire Service and the Ambulance Service meet at the site and form the Onsite Coordination Group to coordinate the response of the three services on the ground. The Framework defines An Garda Síochána as the Lead Agency for this event and therefore a Garda Inspector takes the Chair

One of the first decisions taken by the group is to designate the Ballybeg Arms Hotel, on the outskirts of the town, as a Friends and Relatives Reception Centre[1], specifically dedicated to the families of those who have died at the scene. The people involved, some of whom have witnessed the death of a loved one, while others, arriving later, have seen the dead body of a loved one, are gently moved from the scene and brought to a reception room in the hotel, where initial security is provided by An Garda Síochána. This is an important consideration, in order to provide maximum possible privacy for the families.

[1] A Friends and Relatives Reception Centre is a secure area, operated by An Garda Síochána, for the use of family and friends near the site of the emergency.

The next decision taken by the Onsite Coordination Group is to designate the Ballybeg Community Centre, which is half a mile away, as the Survivor Reception Centre[2]. All of those who survived the incident and are uninjured are directed/assisted to the Survivor Reception Centre, where every effort is made to meet their immediate physical and psychosocial needs. The Civil Defence service is mobilised by the Local Authority as quickly as possible to assist in this work. At the Survivor Reception Centre, details of survivors are documented and collated by An Garda Síochána, who also organise security.

At this stage, at the site of the accident, the Fire Service is continuing the rescue of trapped victims; injured survivors are being triaged by the Ambulance Service, following which the seriously injured are transported to the Regional Hospital in Ballymoor and those with minor cuts and bruises are directed to the Ballybeg Primary Care Centre, 100 yards away; officers of An Garda Síochána are beginning the process of preserving the scene for evidential purposes and taking details of all witnesses to the event.

At 4.01pm the first teleconference of the Community Health Services Coordination Group (formally PCCC Services Coordination Group) is provided with details of the incident by the Health Service Area Manager. Included in this teleconference is the Principal Psychology Manager.

At 4.13pm the Principal Psychology Manager activates the local Health Service Psychosocial Response Plan. This involves:

- Alerting the Health Service Psychosocial Management Team (HSPMT);
- Alerting key resources in external agencies which may be of assistance;
- Establishing the HSPMT Centre[3] ;
- Carrying out an initial needs assessment, including identifying the urgent needs of potentially vulnerable groups;
- Mobilising the members of the Health Service Psychosocial Management Team and their support staff;
- Placing on standby colleagues in neighbouring counties;
- Preparing an outline plan of action;
- Establishing the staff requirements associated with this plan of action, including spokespersons who will be available to speak to the media regarding the psychosocial support aspects of the event;
- Issuing initial instructions to key staff in terms of:
  - Updating prepared resources, such as leaflets, for handing out to members of the public, with information added specific to this event, such as, telephone numbers, drop in centre details, and specific pathways to support and care;
  - Distributing information resources
  - Updating and making live the relevant section of the Health Service and other websites
  - Issuing an initial communication to all GP's in the Ballybeg area, alerting them to the potential emotional and psychological sequelae, and emphasising the escalation path for those people requiring a more significant intervention.

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2 A Survivor Reception Centre is a secure location to which survivors, not requiring hospital treatment, can be taken for shelter, first aid, interview and documentation. It is the responsibility of the Local Authority to establish and run this Centre.

3 The Psychosocial Management Team Centre is an office, or set of offices, where the HSPMT and its support staff can meet and work together on the management/coordination of the overall Psychosocial Response

- Putting in place mechanisms for effective and timely communication to, and feedback from, relevant services in the Regional Hospital, the Friends and Relatives Reception Centre, the Survivor Reception Centre and other such sites, so as to inform decision making.

By 4.50pm the last living casualties have left the site and arrangements for dealing with the bodies of the dead have begun. This involves recording all of the details which will be required for later inquests and enquiries and moving the bodies to a Temporary Body Holding Area, close to the scene. At this stage the situation at the site is still fairly chaotic, with the continuous arrival of parents and relatives of those who may have been involved, in a desperate search for information; representatives of the local, national and international media; and "disaster tourists".

At 5.00pm the first meeting of the Local Coordination Group (LCG) is held by teleconference (later meetings will be held in the County Hall in Ballymoor). This meeting is chaired by the local Garda Chief Superintendent and attended by senior representatives from the Local Authority and the Health Service. This is the group which provides strategic direction to the inter-agency response and also provides a link between the local response and relevant Government Departments.

Over the succeeding hours, regular teleconferences/meetings are held of the LCG, the Health Service CMT and the Community Health Services Coordination Group.

At 6.00pm the RTÉ Evening News reports that its best information on the overall position at this stage is as follows:

- 5 children and 3 adults died at the scene;
- 4 children and 5 adults were seriously injured and moved by ambulance to the Regional Hospital in Ballymoor; 2 of these children died following their arrival at hospital;
- 6 children and 2 adults have injuries which are defined as significant but not serious and they too have been moved to the hospital;
- 12 children and 3 adults have minor cuts and bruises and have been or are being treated in the Ballybeg Primary Care Centre;
- More than 100 uninjured but very upset and distressed children and adults (including parents, siblings and spouses of casualties) have been escorted to the Ballybeg Community Centre where they are in the care of the Civil Defence Service and are being comforted by local clergy, as well as by locals who claim to have training in and experience of counselling;
- Fortunately, some children, including all pupils from the infant classes, had already departed for home before the accident happened. Other children, who were not involved, were whisked away home by their parents;
- The local Coroner has been notified of the incident and, on behalf of the Coroner, An Garda Síochána have taken possession of the bodies of the deceased;
- The State Pathologist is on her way to Ballybeg and arrangements are being made for the series of post-mortems which will take place in the Regional Hospital in Ballymoor.

RTÉ also reports that An Garda Síochána has established a Casualty Bureau and the telephone number is provided. Anyone with concerns about a relative, who is missing and may have been involved in the incident, is asked to phone

this number and provide details of the person concerned. Following a matching process, the staff of the Casualty Bureau will return later to the key contacts with whatever information they can provide.

In the meantime, many frantic parents/spouses/relatives/friends are at or heading for the Regional Hospital, desperately seeking information on their loved ones. Hospital security staff and An Garda Síochána have been forced to secure the clinical areas of the hospital, so that the treatment of the injured can proceed. Inside and outside the hospital there are scenes of great grief, as parents, spouses and families hope for the best but fear the worst. There is some conflict with reporters and cameramen, who insist on intruding on the privacy of the bereaved in their distress.

A snap shot of the situation at **6.30pm** on Tuesday evening, from the perspective of the Health Service Psychosocial Management Team (HSPMT), is as follows:

In the **Ballybeg Arms Hotel** the devastated parents, siblings and relatives of the dead are in a state of shock, distress and grief. A number of Health Service staff members have been asked to attend and the first two of these have already arrived.

From the perspective of the HSPMT, the principal issues are:

- How many approved psychosocial responders are available to attend at the Friends and Relatives Reception Centre?
- Is specialist input/advice from the Health Service required?
- Are there adequate resources, such as leaflets, available in order to assist the bereaved?

At the **Regional Hospital** there are a number of groups who are of particular interest to the HSPMT as follows:

- Adults and children who have been injured (and possibly traumatised) by the event;
- The parents, siblings and other relatives of the two children who have died at the hospital;
- The parents, relatives and friends of the children and adults who have been injured and are in the hospital for treatment;
- Parents and relatives of adults and children who were involved in the incident but are not actually in the hospital. Some of these are among those who died at the scene and others include those with minor injuries, who are being treated in the Ballybeg Primary Care Centre, as well as some people who are temporarily unaccounted for in the general confusion.

All of these groups are being provided with some level of psychosocial support by relevant staff of the Regional Hospital.

From the perspective of the HSPMT, the principal issues are:

- Is there a sufficient number of staff, with the requisite levels of competence and expertise, in the hospital to meet the psychosocial needs as the situation evolves?
- Are the training and guidance materials which have been provided to these hospital staff appropriate to the task and do they include integration of their efforts into the overall Health Service psychosocial response?

- Are there adequate resources, such as leaflets, available within the hospital for distribution to those who need them?
- Has a member of staff been designated to provide necessary feedback to the HSPMT?
- Are systems in place to support appropriate data collection?
- Are there clear, workable arrangements in place which will allow for the escalation to the appropriate service of individuals who require a higher level of support?

At the **Ballybeg Primary Care Centre**, some of the adults and children who have been brought there have had their minor cuts and bruises treated and have either moved on to the Survivor Reception Centre in the Ballybeg Community Hall or have gone home.

The situation in the **Survivor Reception Centre** in the Community Hall is still fairly chaotic, with a number of different statutory services, as well as local voluntary groups and individuals, interacting with the survivors in a number of different ways.

There are a number of groups in the hall who are of interest to the HSPMT as follows:

- Adults and children who were present at the event;
- The parents, relatives and friends of the above.

From the perspective of the HSPMT the principal issues at the Survivor Reception Centre are:

- Is additional support/advice needed by the Civil Defence volunteers who are providing a support service in the centre?
- Are there appropriate and adequate resources, such as leaflets, available to the Civil Defence Service for distribution within the Survivor Reception Centre?

In the **wider community**, there are a number of groups who are of interest to the HSPMT as follows:

- Children who attend Ballybeg National School but who, for one reason or another, were not involved in the incident;
- Children who attend Ballybeg National School and who were present when the accident occurred but were whisked away home by their parents;
- Adults (some of whom are teachers in the school) and children who either witnessed the accident and/or viewed the scene in the aftermath of the accident;
- Adults and children who are related to/or are friends of any of the above.

From the perspective of the HSPMT, the principal issues here are:

- Engaging with partner agency NEPS in identifying and addressing the needs and concerns of children, parents and teachers and ensuring that clear communication and working arrangements are in place.

- Identifying the family, community and other services in the locality to which those affected may turn to for support; then engaging and consulting with these so as to identify emerging needs and ensure an effective response.

- Considering the information needs of the public and methods of communication, e.g., the use of media, including social media, schools, churches, youth and sports organisations.

Throughout the evening there are regular meetings of the Local Coordination Group, the Health Service CMT and the Community Health Services Coordination Group. In the main, these meetings are dominated by arrangements for the care of casualties, the care of families, the handling of bodies, liaison with Government Departments and the provision of information to the media.

At 7.30pm there is an inter-denominational religious service in the local church, where prayers are said for all of the victims and the bereaved.

At 8.30pm the Principal Psychology Manager is contacted and advised that the next meeting of the Health Service CMT will be at 9.00pm and a report on the activation of the Psychosocial Response Plan is required for that meeting.

At the meeting the Principal Psychology Manager reports on the arrangements that are in place for tomorrow and subsequent days.

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A snapshot of the situation at 8.00am on Wednesday morning, from the perspective of the Health Service Psychosocial Management Team, is as follows:

The **Friends and Relatives Centre** at Ballybeg Arms Hotel has been wound down, as families have returned to their own homes where they are being supported by relatives, neighbours and friends and begin to make preparations for the burial of their loved ones. The **Survivor Reception Centre** at the Ballybeg Community Centre has also been closed down.

At the **Regional Hospital**:

- There are 2 children and 1 adult in intensive care; 5 children and 5 adults have been admitted to the wards and 2 children and 1 adult have been transferred to Beaumont Hospital, Dublin.

- The bodies of the 2 children who died remain in the Hospital Mortuary.

- Preparations are underway for the commencement of the 10 post-mortems which are likely to start later in the day, continue on Thursday and finish on Friday.

From the perspective of the HSPMT the principal issues are:

- What structure is in place (or will be put in place) to manage the overall psychosocial response, to coordinate the actions across different locations, to collect and process data for all locations, to prepare reports for the Health Service CMT, to prepare media statements, including social media responses, to allocate and relieve staff, to integrate staff from other organisations and other parts of the Health Service into the response and to monitor and quality assure all aspects of the psychosocial response?

- How can the Health Service and other agencies consult and engage with the Ballybeg community and what would be the appropriate time scale in which to do so?

- How can key staff be relieved/replaced in a way that facilitates Major Emergency related work while allowing critical "day to day" issues to also be dealt with?

- How can staff "burnout" be avoided?

- How can the psychosocial response service at the Regional Hospital be maintained; are extra resources required and, if so, where will they come from; is more liaison/coordination/support required and, if so, how can it be provided?

- Is adequate psychosocial support being provided to families who have travelled to Beaumont Hospital to be with the victims who are being treated there?

- How can psychosocial support be provided to families who must take part in the process of identifying victims, which will take place over the next few days, as part of the post-mortem process?

- Who will organise interaction with the Family Liaison Officers of An Garda Síochána?

- What tailored material/resources are required for the various groups which require support in terms of printed material, leaflets, website, Facebook, Twitter, etc.?

- Can material be prepared for issue to all news and social media, for inclusion in articles, etc., about the event which will point those involved towards the advice and support which is available?

- Are there spokespersons available who can speak to the local, national and, possibly, the international media, regarding the psychosocial support aspects of the event?

- Should an information outlet be established in Ballybeg, either in conjunction with a broader inter-agency Information Centre or, if one is not being organised, at the Primary Care Centre, and what individuals are required to man this centre; are such individuals available and what materials/resources need to be available at such a centre and can these be prepared quickly?

- What psychosocial support will be required for families and friends at the upcoming funerals and how will that support be provided?

Appendix 4 – Annual Psychosocial Response Preparedness Appraisal

It is desirable that consistent and effective arrangements are in place across the country which will enable the health services to lead an appropriate psychosocial response in the aftermath of a Major Emergency.

To this end the Health Service Senior Area Manager in each designated Health Service area should carry out and document (or have carried out and documented) an annual appraisal of local psychosocial response preparedness (commencing at the end of 2014).

To facilitate the appraisal process, a form has been prepared for completion by (or for) the Health Service Senior Area Manager at the end of 2014. While the format of this appraisal is self assessment, answers should be evidence based – with written evidence (e.g., lists of group members, dates of meetings, exercise reports) where possible.

This form will be changed in later years as the psychosocial response preparedness process develops and evolves.

Before the end of January each year copies of the completed form for the previous year should be forwarded to:

- The relevant Health Service Regional Manager, and
- The National Directorate for Mental Health

Annual Psychosocial Response Preparedness Appraisal Form – 2014

Health Service Designated Area: .....

Health Service Senior Area Manager: ..... Date: .....

Please indicate, with a tick in the appropriate Yes or No box, whether, or not, each of the following statements is an accurate reflection of the position within the area.

		Yes	No
1	Responsibility for leading psychosocial response preparedness in the Area has been formally assigned to	☐	☐
2	A local Health Service Psychosocial Management Team is in place and met ..... times during the year	☐	☐
3	A local Psychosocial Response Plan, with appropriate activation arrangements, is in place, dated	☐	☐
4	All key Health Service staff in the Area have been trained so that they are familiar with the Plan and their roles in it.	☐	☐
5	A network analysis of local psychosocial services has been completed and incorporated, where relevant, into the local Psychosocial Response Plan	☐	☐
6	Relevant Service Level Agreements have been enhanced, where appropriate	☐	☐
7	A Partner Agencies Psychosocial Group is in place and met ..... times during the year	☐	☐
8	Appropriately trained Health Service personnel are available to deliver on key roles in the Strategic Stepped Model of Care	☐	☐
9	Local psychosocial responders have been approved, as appropriate	☐	☐
10	Liaison has been established with local acute hospital services in terms of the provision of care, collation of data, etc	☐	☐

Appendix 5 – Working Group Membership and Consultation Process

MEMBERSHIP OF THE WORKING GROUP

Ms. Catherine Brogan, National Planning Specialist, Mental Health, HSE - Chair to June 2013 - Executive Director, Samaratins Ireland, from June 2013

Mr. Pat O'Riordan, Specialist in Emergency Management, HSE National Emergency Management Office - Chair from June 2013

Dr. Eddie Murphy, Principal Psychologist, Manager PCCC Psychology Services, HSE Carlow/Kilkenny Community Care Services

Ms. Angela Flavin, Senior Clinical Psychologist, PCCC Psychology Services Donegal, HSE West

Ms. Una Marren, Deputy Director of Nursing/Policy and Procedure Co-ordinator, Mater University Hospital, Dublin

Ms. Helena Cogan, Co-ordinator of Training and Support Services, Suicide Resource Office, HSE South

Dr. John Tobin, College of Psychiatrists of Ireland

Mr. Jim Ryan, Specialist in Mental Health, HSE

EXTERNAL ADVISOR TO THE WORKING GROUP

Professor Jonathan I. Bisson, Professor in Psychiatry, Institute of Psychological Medicine and Clinical Neuroscience, Cardiff University

THE FOLLOWING WERE CONSULTED IN JUNE 2013

The National Vision for Change Working Group

The National Strategic Management Group

The College of Psychiatrists of Ireland

The Irish College of General Practitioners

The Mental Health Commission

The National Educational Psychological Service

The Heads of Psychology Services Ireland

Mr. Martin Rogan, HSE Assistant National Director, Mental Health

Mr. Gavin Maguire, HSE Assistant National Director, Emergency Management

Mr. Gerry O'Dwyer, RDO, Dublin/Mid-Leinster, HSE

Dr. Ian Daly, HSE National Clinical Lead for Mental Health

Mr. Alan Doran, Principal Clinical Psychologist, HSE Dublin/North East

Ms. Eithne Cusack, HSE Nursing and Midwifery Practice Development Unit

Mr. Brian Murphy, HSE National Primary Care Manager

Dr. Gerard O'Neill, Director of Counselling, HSE South

Ms. Fiona Ward, Director of Counselling, HSE Dublin/North East

Ms. Susan Kenny, National Office for Suicide Prevention

SUBMISSIONS ON THE DRAFT GUIDANCE DOCUMENT WERE RECEIVED FROM

Mr. Jim Walsh, Training & Development Officer, Irish Advocacy Network

Ms. Anne Barrett, Social Work Team Leader, Carlow/Kilkenny Mental Health Services

Mr. Vincent Cronly, HSE Emergency Management, Dublin Mid Leinster

Dr. Ed O'Dea, Principal Clinical Psychologist, St. Joseph's Hospital, Limerick

Ms. Sharon Eustace, Senior Psychologist, National Educational Psychological Service

Ms. Marie Faughey, Area Manager Children and Family Services, HSE Dublin South West, Kildare West Wicklow

Dr. Stephen McLearie, Consultant Child and Adolescent Psychiatrist, Clinical Director, Mater Child and Adolescent Mental Health Service

July 2014

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Office of the AND Mental Health, HSE,
Oak House, Millennium Park, Monread Road, Naas, Co Kildare.