

Prioritizing care during the acute phase: the prominent role of basic psychosocial life support

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Summary

The issue of basic psychosocial life support after disasters is an important one.

People who are affected by disasters can experience severe distress and may need psychosocial support. There are however still many questions about service design and effectiveness of psychosocial support.

During the process of the Targeted Agenda Programme ‘prioritizing care during the acute phase: the prominent role of basic psychosocial life support’ a team of experts reached consensus on some important issues concerning psychosocial first aid, civil participation and risk communication. The experts come from many different backgrounds which supports the notion that psychosocial care deserves special attention within disaster relief programme’s involving all disciplines and all responsibilities.

Introduction

When disasters strike they are sudden, unexpected, and “earth-shattering” to those affected. Those who are directly exposed often talk about how their lives have been radically changed. They describe a state of confusion, pervasive anxiety, and helplessness.

Disaster victims also speak about things not being the same, of how their inner sense of safety and their ability to count on the stability of their environment has been lost. Some also speak about feeling powerless, and having lost the structure of their daily lives.

Disaster stress research studies have revealed that these events affect the lives of people for years and even decades. Understanding the effects of these disaster events upon victims’ minds, bodies, relationships, and behaviour, is crucial to the planning and organization of the psychosocial care and for the professional field staff who are involved in disaster relief. The needs of the affected people should be the starting point for a tailor-made approach to psychosocial care.

Impact, the Dutch knowledge-and advice centre for post-disaster psychosocial care, recently participated in the 15th World Congress on Disaster and Emergency Medicine 2007, held in Amsterdam, the Netherlands. Its Targeted Agenda Program was entitled 'Prioritizing care during the acute phase: the prominent role of basic psychosocial life support'.

The aim was to formulate consensus statements on psychosocial care as an integral part of the broad field of disaster relief. Together with an international team of experts, various issues were raised, including psychological first aid, civil participation, resilience and risk communication. The result of the international Targeted Agenda Programme on basic psychosocial life support aims to contribute to the mitigation of the effects of disasters on the affected population by giving directions for good practices for those who are involved in the first response after a disaster.

Directing and promoting good practice in policymaking with regard to post-disaster psychosocial care requires a clear vision of what constitutes psychosocial care. What is the aim of psychosocial care, how should it be delivered and who is in need of psychosocial care? The Targeted Agenda Program (TAP) during the World Congress on Disaster and Emergency Medicine 2007 (WCDEM2007) in Amsterdam allowed Impact to discuss these questions with other experts in the field of disaster medicine. The process and conclusions of the TAP during WCDEM2007 marks an important step towards a further integration of psychosocial care into the broad field of disaster relief.

Methods

Impact joined the TAP Programme as part of the World Congress on Disaster and Emergency Medicine which took place in Amsterdam in the Netherlands, May 2007. WCDEMs' overall theme was: Preparedness: Knowledge, Training and Networks. One of the interesting features of this Congress was the introduction of a Targeted Agenda Programme (TAP). A TAP is an interactive and dynamic instrument to catalyse knowledge gain. Impact's TAP focused on the role of basic psychosocial life support. It hosted the TAP: "Prioritizing care in the acute phase: the prominent role of basic psychosocial life support." Impact's goal was to develop consensus statements on the role and standard features of basic psychosocial care in the acute phase with regards to red, white and blue (fire brigade, ambulance services, police) including defence and volunteers.

After having decided on the topic of the TAP, the foundation for its success was laid by selecting a number of experts in the field of basic and advanced psychosocial life support. The experts' collaboration was solicited and after having received their consent, the second stage got on its way. This stage was dominated by the use of a specific webpage for the

TAP. To facilitate a discussion on the website among the international experts and TAP leader, concerning the role of basic psychosocial life support, statements were put up, opinions were expressed, information and best practices were shared and literature was disseminated. The accumulated input deriving from this exchange on internet sharpened the thinking of the experts and TAP team. During the three WCDEM congress days these more fine-tuned concept statements were discussed together with the experts, the Impact TAP team and other congress members. It resulted in the formulation of final statements regarding basic psychosocial life support.

First of all Impact formulated the following questions: Could the concept of acute psychosocial first aid be considered an important component of the caretaking system, next to life saving activities? What role could be ascribed to self reliance and risk communication? Should acute psychological first aid be an integral part of the disaster planning? Should citizens and existing (mental) health infrastructure play an important role in the acute phase? Does clear risk communication by the appropriate people make a difference, ensuring that acute psychosocial first aid will help creating the desired results and does it provide the citizens the opportunity to act adequately?

Secondly the TAP website was launched, where the discussion on the relevant issues amongst the experts was to take place. To facilitate the discussion the experts were first asked to introduce themselves and to reflect on a number of concept statements. They were requested to express their opinions on the statements, to highlight specific issues or to add new ones.

A three track approach

Following initial online responses a three-track approach was followed. The subject of basic psychosocial life support was broken down into specific issues. Experts were assigned to each track according to their area of expertise. The leading questions for the web discussion and a summary of this discussion are presented below.

Track 1. Acute Psychosocial First Aid

- Identifying the level of urgency: what is meant by “acute”?
- Acute Psychosocial First Aid: Do’s and Don’ts
- How might this affect rescue workers?
- How might this affect the education and training of rescue workers?

Track 2. Civil participation / resilience: an organizational perspective

- Can members of the public assist in providing acute psychosocial first aid. If so, how?
- How should assistance provided by members of the public be included in disaster planning and protocols of rescue organizations?
- How to make the most of 'what comes naturally'?

Track 3. Risk communication

- Risk and crisis communication are psychosocial interventions.
- Risk and crisis communication are an intrinsic part of acute psychosocial First Aid.

Summary of the web discussion track 1

- The definition of the acute phase takes the situation into account and is thus context and severity specific.
- Psychosocial interventions should start from the first moment.
- Paramedics, firefighters and other rescue workers can provide the earliest psychosocial interventions.
- Paramedics, firefighters and other rescue workers need extra education and training to provide early interventions
- Psychological triage should be operationalized in concrete directions for the professionals
- Showing empathy should be done in a victim specific way, in other words, be sensitive to the needs of the victims
- Debriefing should be very well managed.

Summary of the web discussion track 2

- Most initial help comes from by-standers.
- Members of the public can contribute to help in the acute phase. Therefore they should not be pushed aside but given be acknowledged for their role. Consider however the safety of the civil participants.
- Simple mnemonics should be developed
- Designate and train people to take the lead in citizen's response.
- Use community resources and public communication.
- Use schools for teaching disaster preparedness: knowing and training behavior.
- To what extent should we put effort in fostering self-reliance in civilians?

Summary of the web discussion track 3

- Accurate, timely, comprehensive, trustful and clear communication is absolutely vital to minimize adverse psychosocial reactions. Do's: What, who, when, where, how, why, using what? Make sure every specific group in the community will be reached (e.g. minorities, disabled).
- Communication means balancing between awareness and fear. Giving information that is reassuring versus creating fear.
- In the preparedness phase: beware of creating unnecessary fear (to what extent do we need to communicate about and prepare for events that probably will never take place?).
- In the post-event phase: Communicate!
- Trust is crucial. Do not hide information.
- Rumors are everywhere. The media will fill every vacuum. Make deals with the media.

On the Congress day the experts were asked to give a presentation from their respective fields of expertise with regards to the TAP subject. The discussion focused subsequently on the 3 specific tracks that had been introduced during the internet period. Questions that were addressed ranged from what to do or not to do during the acute phase, the role of member of the public within the disaster field, the importance of risk and crisis communication as an important psychosocial life support intervention. The following day the discussion continued, also stimulated by congress members who joined the sessions which at some moments were open to all participants. The result of this hard but inspiring work became clear on the last day when the final statements were presented to the Congress. Statements embodying the work that had been started many months before. First an outline of the different presentations is described and then the final statements are formulated.

Track 1 Acute psychological first aid

In The Netherlands, the medical assistance in times of a disaster is an integral part of disaster management and is designed to provide the best possible treatment to as many victims as possible. The national disaster structure, the Medical Assistance in Accidents and Disasters (Geneeskundige Hulpverlening bij Ongevallen en Rampen: GHOR), consists of an operational partnership of both medical emergency and psychosocial service organisations.

Psychological first aid is part of the planned activities in the acute phase and will be considered from the first moment. Since The Netherlands is a relatively low risk country for disasters, improvements in preparation and expertise has to be based on lessons learned from other countries and evidence based guidelines with do's and don'ts

Experiences from other countries have demonstrated that also acute psychological support while the disaster is still in progress (peritraumatic support) by fire, rescue and emergency medical personnel appears to be possible. So rescue workers play a role in giving psychological first aid. On scene counselling by getting close to the victim, to judge the situation of the victim, looking at the victims emotional reactions and when he is in pain helping him to concentrate on other things such as controlling his breath for example..... Specific training allows fire or rescue services personnel to influence the victims' sense of control, pain perception, perception of life threat and anxiety: the most important predictors of long term traumatisation. Other issues about what should or should not be done by first aid and rescue workers needs further studies. For example: what can rescue workers offer to family members that are not injured. Each answer with respect to a given target group of disaster victims could be situated in a global 3D-framework consisting of type of victims (primary, secondary and tertiary victims), type of prevention (primary, secondary and tertiary prevention of post-impact sequelae) and type of event.

This model leads to a concept of 'psychological triage' which should be further operationalized as a tool for psychosocial care tailored on the type of the victims. For example to give priority to the most urgent: those who are conscious, confronted with terrible images, who have no room to move and those who are very aroused.

Also the debriefing of the rescue workers is important. The psychosocial consequences for rescue workers are often managed by debriefing them after the incident. That the operational debrief phase needs to be impeccably managed became clear from experiences . of the London Ambulance Service following two major incidents. After a train crash in 1999 where 31 people died and over 100 injured, the debrief following the train crash was poorly handled with little structure, resulting in anger, and frustration. After the 7th of July 2005 bombings, lessons had been learnt and the feedback from staff was very supportive of the way the post incident support was handled.

It is recommended separating out the technical from the emotional debriefing. The focus of the operational debrief should be on practical issues such as preparation, response and lessons for the future. Emotional debrief on the other hand should be part of routine activity and not only crisis driven. Research based on the London experiences concluded that proportionality was vital. Whilst every ambulance worker should be treated on its merits, most of the involved ambulance personnel recovered from a traumatic incident with quite low

levels of support or intervention. Only in a minority of cases more expert help and support was required.

track 2: Civil participation and psychosocial first aid

Since the importance of the matter and the reality of civil participants being first on the scene of the incident it is sensible to account for their participation in disaster relief. The challenge is to look into what can be done to influence the public on matters concerning civil participation but also to the long term mental health risks.

Civil participation includes medical aid and psychosocial first aid from the very first moment after the incident: medical and psychosocial aid from involved persons, bystanders and trained first aid volunteers. Civil participation in medical and psychosocial aid is reality in case of incidents and mass emergencies.,

Questions are how far should civil participation go? How can civilians protect themselves from injuries and infections and what are the psychosocial consequences, for example on developing PTSD, for civilians involved in the response after a disaster.

It is widely accepted and the available scientific evidence also points into this direction that early interventions make a long-term difference, this is obviously very true for the medical aid, but is also true for the psychological first aid.

Citizen response to disaster is however largely underestimated in Europe. Citizens are much more capable of helping themselves and the fellow citizens during the response to disasters than official organs acknowledge. There are three myths in relation to the reaction of people as a response to a disaster: that they will panic, that they are helpless and that they are malicious. In fact none of these three myths proves to be true. The public response is one of self-reliance: to help oneself and to help others. This also includes the potential contribution to help by providing basic psychosocial life support. Guided by professionals ordinary citizens prove to be of great psychosocial support for victims thus multiplying the usually sparse professional capacity. A paradigm shift within the governmental organisations is necessary in order to fully use the potential contribution of citizens. The questions that were put forward on how far this participation should go and that we have to be aware of the consequences for citizens should be kept in mind and should be answered in time.

Track 3:

Entering the public stage during crisis

Information can be considered a psychosocial intervention. This underlines the importance of information for victims of a disaster. Providing affected people with accurate, factual

information on the incident itself is essential in assisting them in the process of recovering from what has happened. It is important that people have access to this information. Emergency management is based on the ability to inform the public, the affected target groups and other operations. Credibility is a prerequisite for the confidence and trust of the public in emergency management. This trust must be based on communication in everyday situations and on communication in times of 'peace'. During emergencies when individuals and society are in crisis the correctness and timeliness are crucial. Ideally information for the affected people should be available before it is released to the press. Also during these events risks and anxiety must be taken seriously and met with the appropriate action and information responses. Public institutions are both responsible and entrusted to act in emergencies. Citizens presume that these authorities will take care of them. People expect municipalities, county councils, government agencies and politicians to handle emergencies. In times of crises there are three important aspects: the crisis itself, the way the formal and responsible organisations and authorities handle the crisis and the perception of the public of the crisis.

Different tools and aspects in the crisis and risk communication area form a prerequisite for effective risk and crisis communication. Work to build networks of communicators and other information professionals in emergency management and other related areas. Creating these networks and getting to know the key people, prior to the events makes it much easier to operate during times of crisis. Understanding that there are different target groups to communicate with, makes it easier to package different types of information .

Building different formalised groups of communicators at local, regional and central levels helps gain knowledge of the information needs of each target group.

When authorities cannot provide information, there is a major risk that anxiety can spread and information needs will be more difficult to meet. In this event, authorities will have to respond to questions from the general public and those affected. Previous disasters and emergencies have shown that information needs from the general public are great and that the media to a large extent become the information bearers.

Final Statements

Track 1: Acute Psychosocial First Aid

1. Psychosocial care should be an integral part of disaster planning and preparation.

2. Psychosocial care deserves special attention within disaster relief programs, involving all disciplines and all responsibilities.
3. Psychosocial aspects should be considered from the first moment.
4. Reaching and maintaining the required standards of psychosocial care warrants investments in education, training and rehearsal; research and development and good practice.
5. Raising awareness for psychosocial issues should be an integral part of core training of rescue workers.
6. During the acute phase, victims need practical, social and emotional support.
7. In early psychosocial interventions, the specific characteristics (e.g. cultural or religious) of the situation and the victims should always be taken into account.
8. Psychosocial care during the acute phase is primarily practical, non-medicalizing and fits to the needs of victims and specific target groups.

Results in terms of concrete directions for first responders on the basis of the expert opinion

Do's and Don'ts for first responders:

- Do's (on the spot, e.g. without freedom of movement): caregiver has to care for his/her own safety, help other caregiver to assess the most urgent needs of the victim, stay 'close' to the victim –build a 'bridge', make contact, see how he/she is, introduce yourself, check breathing, assist the victim in reducing anxiety by calming down breathing, act on the experienced life threat anxiety and arousal of the victim – provide reassurance-. Stay calm, do what comes naturally. Don't make promises or unrealistic expectations. Be aware of cultural / religious specific aspects which may be misleading (e.g. expression of anxiety or pain).
- Do's (acute phase): Give information. Make contact with relatives possible. Stay calm, do what comes naturally. Use resilience and self reliance.
- Don'ts (on the spot): Using words like 'pain' or other suffering-related words.
- Don'ts (acute phase): Providing confidential, incorrect or irrelevant information. Separating children from their parents or families.

Track 2: Civil participation / resilience: an organizational perspective

1. Members of the public can be extremely helpful during the acute phase.
2. Proper organization, guidelines and training are required to gain maximum benefit from the assistance provided by members of the public.
3. Public information can address the issue of self-reliance.

4. During the acute phase, psychosocial care should be provided in conjunction with standard health care and tap into the social structure of the community (churches, schools, victim support groups).

Track 3: Risk communication

1. Risk- and crisis communication are crucial preventive psychosocial interventions.
2. Miscommunication could seriously harm the victim's psychosocial wellbeing and mental health.
3. Communication is about striking the right balance between awareness and fear.
4. Communication is about key figures gaining trust and credibility and addressing public risk perception and understanding.

Concluding remarks

With the Targeted Agenda Programme held during the World Congress on Disaster and Emergency Medicine 2007 the participating expert group has contributed in a very important way to the prominent role of basic psychosocial life support after disasters. Experts from different backgrounds have been working together on this topic. And consensus is reached that psychosocial life support can be delivered by first responders with different responsibilities like policemen, fire-fighters, ambulance personnel, volunteers and of course professional with a psychological background. Also citizens and bystanders play an important role in this matter. One of the results of this expert meeting is a simple guideline with do's and don'ts for first responders. This first draft should be tested in practice and evaluated. Maybe this can be a start for the next WCDEM conference in 2009 in Toronto. Who wants to take the lead in this interesting and continuing process?

The cooperation with the WADEM board and the psychosocial task force were inspiring and it is an opportunity to support the work which was done during the Targeted Agenda Programme “Prioritizing care during the acute phase: the prominent role of basic psychosocial life support”. It is the wish of the authors that this document can be used during the next world conference of the WADEM to further develop the expertise and knowledge of high quality psychosocial care in disaster relief.

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