PRINCIPLES – APPROACH – GOOD PRACTICE

Preparing Scotland

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

Supplement to
CARE FOR PEOPLE AFFECTED BY EMERGENCIES

November 2013

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Executive Summary

Emergencies and disasters can harm the health of people and communities in many ways. Often, the direct physical effects are readily seen, while the impacts on people's mental health and wellbeing may be less obvious and are sometimes hidden. Minimising the suffering of individual people, families and communities, and averting the risk of emotional and psychological injury are important parts of the response to any emergency.

This guidance makes recommendations that are relevant to all Category 1 responders and other organisations. It will be of particular interest to those involved in the wider Care for People response, including:

- Local authorities

- Health Boards, and

- Third sector organisations

A stepped care model is recommended, based on the principles of psychosocial care as exemplified by Psychological First Aid. This model recognises that people who are involved in serious incidents generally respond with great resilience. Although some degree of distress is common, it is usually temporary, and the majority of people do not require the support of mental health services.

The guidance recommends that all responders should be able to deliver Psychological First Aid and should be aware of the different ways in which people react psychosocially to emergencies. It also recommends that they should understand how to make referrals for the small minority of people who may need specialised mental health interventions.

Help with practical difficulties following emergencies and the opportunity to participate in the recovery phase can be of great importance to maintaining wellbeing. Therefore, psychosocial care is closely connected with other aspects of the response, particularly Care for People, Recovery and Public Communications strategies. This means that an integrated approach to planning and responding is essential.

The guidance makes recommendations for each stage of an emergency, and provides a framework for planning, training and service preparation. Its timeline is based on the principle that assistance may be required over an extended period.

The recommendations draw on Scottish, UK and international sources of expertise including work on behalf of the UK Government for the North Atlantic Treaty Organisation (NATO) Joint Medical Committee and by the European Network for Traumatic Stress (TENTS) programme. In particular, they are based on *Guidance for Responding to the Psychosocial and Mental Health Needs of People Affected by Disasters or Major Incidents*[1].

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1   Williams R, et al. *Guidance for responding to the psychosocial and mental health needs of people affected by disasters or major incidents*, 2009. Available at: www.healthplanning.co.uk/principles

Questions to ask

Although psychosocial problems may often be hidden during the aftermath of an emergency, it is important that responders are aware of this aspect of caring for people and are equipped to provide the appropriate support. The following questions can be used to prompt discussion about how well prepared responder agencies may be:

1 Do you respond to emergencies in which your staff or members of the public might suffer psychosocially, e.g. where there is loss of life, physical harm, threats to personal safety, loss of housing, or economic hardship?

2 All responder agencies have the potential to lessen or aggravate the psychosocial impacts of emergencies – have your plans been reviewed from this perspective?

3 Could you or your staff provide psychological first aid?

4 Do you have effective links with partner organisations to ensure that specialist advice on psychosocial matters is available when planning for emergencies and when responding?

5 Do your public communications plans and other advice consider the potential psychosocial impacts of emergencies?

6 Does your training and exercising programme include the management of the potential psychosocial impacts of emergencies?

Contents

Note on the legal status of guidance

The guidance is advisory only and should be read in conjunction with any relevant legislation. This guidance is not, and is not meant to be, a comprehensive description of applicable legislation or of any legal obligations. If you are in any doubt about any legal obligations which are contained in any applicable legislation or otherwise, you are advised to seek your own independent legal advice.

1 Introduction

The aim of this guidance is to assist Category 1 responder organisations to prepare and implement effective responses to the psychosocial and mental health needs of people who are affected by emergencies.

Although the more serious psychological and mental health impacts should be managed by health care specialists, responders from all agencies can influence the mental wellbeing of those affected. This includes those affected directly, the wider public and also the staff of responder organisations themselves. This guidance is therefore also relevant to anyone who may be involved in the wider Care for People response, including third sector organisations and staff in health and social care services.

The approach recommended is applicable to all ages from children through to older people, and is relevant before, during and after emergencies. It aims to provide a model of care that promotes the resilience and psychological wellbeing of survivors, people who have been bereaved, those affected indirectly and the wider communities, as well as staff of all the responding services.

The guidance recognises that each incident will have unique features, challenges and potential constraints, and it acknowledges that local circumstances may vary significantly. For these reasons the guidance is deliberately flexible and non-prescriptive, so that it can be adapted and applied to specific conditions as is required.

It has been prepared under the auspices of the Scottish Government Health and Social Care Directorates and should be used in conjunction with the Scottish Government's documents: *Preparing Scotland: Recovering from Emergencies in Scotland* and *Preparing Scotland: Care for People Affected by Emergencies*[1].

The guidance aims to enable resilience planners to design and plan a coordinated response, and to develop suitable preparatory training. This will involve staff from the health care sector, social care, other statutory responders and the third sector, particularly those with roles in humanitarian assistance. It is expected that the guidance will inform the work of Care for People teams in Local and Regional Resilience Partnerships and that they will apply its recommendations in the development of effective local and regional plans.

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1   Both available at www.readyscotland.org/ready-government/preparing-scotland/

2 Definitions

The term **emergency** is used throughout this document as it is defined in the Civil Contingencies Act (2004). It describes an emergency as:

- an event or situation which threatens serious damage to human welfare

- an event or situation which threatens serious damage to the environment or

- war or terrorism that threatens serious damage to security

Other terms are used as follows:

Psychosocial refers to the psychological, emotional, social and physical experiences of people in the context of emergencies.

Reaction refers to the experiences, difficulties and problems that may affect people after emergencies.

Mental disorder refers to a clinically recognisable set of symptoms and behaviours which are generally associated with distress or disability, where people's reactions, emotions and behaviours are more intense, frequent, sustained or incapacitating than might be expected of the general population.

Social support refers to the social interactions that provide people with actual assistance, and which also embed them in a web of relationships that they perceive to be caring and readily available in times of need.

The document distinguishes between those psychosocial reactions that are very common and not usually pathological, and mental health reactions that may be symptomatic of mental disorder. Both kinds may have emotional, psychological and behavioural components. Needs that arise from psychosocial reactions are termed psychosocial needs, and needs that relate to mental health reactions are termed mental health care needs.

3 Core Principles

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

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

Effective social support plays a vital role in people's recovery following emergencies. There is evidence that supportive social networks can help people to cope with traumatic events and can protect against the development of stress-related mental illness.

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

Arrangements should recognise that people who are affected by emergencies may be able to function well for some time after the event(s) but may develop psychosocial problems or mental disorders later, and sometimes much later. Arrangements should also recognise that a small minority of people may require mental health care over extended periods.

Despite the general resilience of people affected by emergencies, a minority may require screening, surveillance and clinical assessment. These will be people who continue to show high levels of distress or who have been identified as being in an "at risk" group.

People who become psychologically unwell following traumatic experiences may develop a number of disorders. These include alcohol and substance misuse, anxiety disorders and phobias, adjustment disorder depression, or post-traumatic stress disorder. Children may show their distress in other ways, for example, separation anxiety or behavioural problems.

Some people, families and communities may experience more adverse effects and may require longer-term, psychosocial support and mental health care.

A comprehensive response to psychosocial and mental health care needs requires a multi-agency approach. This includes coordinating services from social care and health care providers, emergency responders and non-governmental organisations.

As with other aspects of caring for people and managing the recovery following an emergency, the best outcomes are likely to be achieved by working in partnership with the affected people and communities, and by facilitating a high level of self-determination by those affected.

A stepped care model should be used that begins by attending to basic needs (such as safety, security, food, shelter, acute medical problems); it should then proceed through responses

made by people, families and communities to non-specialised support services; and lastly to specialist mental health care services.

The stepped model of care should be based on the principles that underpin Psychological First Aid (PFA). Specific formal interventions such as single session individual psychological debriefing should not be provided as these have not been shown to be effective, and may cause harm for some participants.

Psychological First Aid

There are a number of components of effective psychological first aid, listed below. The components should be modified to match the needs of each individual. A child, for example, will require a different explanation of trauma reactions than an adult. There is no particular order to follow, as this will depend on the people affected and on the emergency.

<table>
<tr><td>Key components of effective Psychological First Aid</td></tr>
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- provide immediate care for physical needs

- protect from further threat and distress

- provide comfort and consolation for people in distress

- provide practical help and support for real-world-based tasks (e.g. arranging funerals, information gathering)

- provide information on coping and accessing additional support

- facilitate reunion with loved ones where possible and/or connection with social supports

- provide education about normal responses to trauma exposure including two essential elements
    - recognising the range of reactions
    - respecting and validating the normality of the post-trauma reaction

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The likelihood of a person developing more serious psychosocial problems or mental disorders will depend on many factors including the intensity and duration of their exposure to emergency-related stressors, certain prior experiences, and the availability, or otherwise, of social support. The stepped care model should be applied in ways that include a clear pathway for accessing specialist services for those people who are thought to be at particular risk.

Early psychological reactions to emergencies can be difficult to distinguish from the symptoms of disorders that may develop later. Responders and staff in health, social and welfare services should be provided with basic education and training about psychological responses to emergencies across the age range. This will help to avoid inaccurate estimates of the prevalence of disorders.

The specific needs of children who are affected by emergencies should be addressed and support and advice should be provided for parents and/or carers. Education services have an important role in restoring and normalising community life for children and their families; they should be included in emergency planning.

People with chronic (long-term health conditions), with physical and mental disabilities (including severe mental disorder), or who are elderly may need additional support following emergencies. Community resources should play an important role in restoring and normalising community life for these people and their families.

Plans should include specific provisions for the psychosocial care of the staff of responder organisations linking with occupational and other relevant arrangements.

Attempts should be made to identify and follow up non-professional responders (that is, civilians who have assisted in the emergency response) as they may have had increased exposure to potentially traumatic experiences without having access to the organisational support of professional emergency service responders.

Some groups of people may be at risk of discrimination or violence in the aftermath of emergencies and may need extra help to stay safe.

Responders should work with community leaders to identify the needs of those people who are affected, taking into account cultural factors, such as language, faith and belief, and other needs. Some sections of the faith communities have established emergency plans and, where possible, their specific requirements should be integrated into the contingency planning infrastructure and arrangements.

The model of care should be capable of being evaluated. By working with appropriate partner organisations, standards for research, evaluation and information-gathering should be developed and planned before emergencies occur. The object of research should be to identify and improve best practice for people who are affected by future emergencies.

The following timeline outlines the development and delivery of psychosocial and mental health care at each stage of an emergency. The time intervals are approximate and are intended to offer an indicative framework for planning, training, and service preparation.

4 Caring for People Over Time

4.1 Preparing in advance

Health Boards have an advisory role in the development of the psychosocial resilience and wellbeing of adults and children, families, communities, schools, workplaces and other groups through public mental health programmes.

Care for People teams should identify senior mental health and social care professionals from the Health Board and local authority to give real-time advice to responders during both the emergency response and recovery phase. Advice should be available to all levels of responders and coordinated with other specialist support, e.g. Scientific and Technical Advice Cell.

Care for People teams should develop arrangements to utilise local expertise to understand specific local issues and identify the most appropriate community resources (e.g. schools, faith groups, youth clubs, leisure facilities) to draw on in an emergency.

Care for People teams should include people who have been affected by past emergencies when developing and exercising plans, and should be aware of the support available from organisations such as Disaster Action[2].

Health, social care, education and third sector services should identify in advance those people within their organisations with appropriate skills who could contribute to the psychosocial care response. Appropriate screening should be conducted for suitability.

An essential component of a comprehensive psychosocial response is providing information for people and communities that are affected. This should be consistent with the broader Care for People response and communications strategy and should:

- signpost access to additional services
- acknowledge and respect the possible range of reactions across the age range
- protect and promote social and community relationships
- involve the public and the media
- be comprehensive in its reach
- consider specific psychosocial needs of different groups of people

Further guidance on communications is available in *Preparing Scotland: Warning and Informing Scotland*[3].

All agencies should ensure that their staff receive appropriate training in the psychosocial aspects of emergencies. This should include emergency service staff, those working in local authorities (particularly welfare and social care) and health services (particularly general

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2   Disaster Action can take an advisory role to the Care for People team and/or may be involved in direct service delivery when they have been approached by those affected. Information is available from Disaster Action at http://www.disasteraction. org.uk/default.htm

3   See *Preparing Scotland: Warning and Informing Scotland* and *Preparing Scotland: Warning and Informing Scotland - Using Social Media in Emergencies,* both at www.readyscotland.org/ready-government/preparing-scotland/

practitioners). Where third sector organisations are involved in a response or care provision, consideration should be given to the benefits of joint training with statutory providers. Training should be developed in conjunction with specialists in psychosocial and mental health care and should include:

- the psychosocial and mental health effects of emergencies on people of all ages

- the principles of psychosocial care and Psychological First Aid

- awareness of possible longer-term consequences

- awareness of referral pathways for people who need more specialised care

- self-care for staff

The multi-agency training programme should include explicit arrangements for the testing and exercising of the psychosocial and mental health components of the emergency plans.

Responder agencies should agree on the types of personal information that will be collected from people who are affected by emergencies and should ensure that paper and electronic systems are compatible with respect to information sharing.

Agencies in all areas of service provision should be aware that there is clear legal power to share information in the context of emergencies and they should develop information sharing protocols (particularly about identifiable people) as part of their data-sharing partnership arrangements. Specialist advice should be sought on data protection and duties of care as they apply to different organisations[4].

The following factors are associated with an increased likelihood of dysfunctional distress and risk of developing post-traumatic stress disorder:

- perception of high threat to life

- physical injury

- circumstances of low controllability and predictability

- the possibility that the emergency might recur

- an experience of disproportionate distress at the time

- experience of multiple losses (of relatives, friends or property)

- exposure to dead bodies or grotesque scenes

- a high degree of destruction of community infrastructure and social networks

- perceptions of limited social support and/or actual lack of this

- pre-existing or previous mental disorder

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4   See http://webarchive.nationalarchives.gov.uk/+/http://www.cabinetoffice.gov.uk/ukresilience/preparedness/informationsharing.aspx

Agencies that deliver care should have processes in place to support staff and to recognise early signs of their distress, possible secondary traumatisation and experiences of burnout. This should be available to volunteers and interpreters involved in the response. Recommended interventions include peer support programmes.

Communications resources relating to psychosocial impacts should be integrated with the broader Care for People and Public Communications strategies coordinated by the Care for People and Public Communications Groups[5]. These should also dovetail with pre-existing material available from government sites and statutory sources.

Agencies should ensure there is appropriate specialist input when preparing websites concerning humanitarian, welfare, psychosocial and mental health matters, including draft or "dark site" material prepared in advance.

The content of leaflets should take account of the needs of different groups of people who might be affected by an emergency such as survivors, people who are bereaved and children. While every emergency is unique, it is likely that materials and text produced in response to other incidents can be adapted to fit the current situation.

4.2 During the first week

Mental health and social care professionals should provide specialised advice to the people responsible for managing each level of the response. The advice should emphasise that initial responses should be based on the principles of psychosocial care as exemplified by Psychological First Aid.

Responding agencies should gather information about people affected by the emergency including their contact details and personal circumstances so that follow-up support can be offered as required. Recording systems should include the facility to collect information on those people considered to be at risk, such as people who have been injured, bereaved or made homeless as a result of the emergency.

Formal screening of everyone affected should not be conducted because there are no measures of sufficient sensitivity and specificity to make this intervention beneficial. Rather, the psychosocial response should be aimed at people who have been assessed as being at risk or members of vulnerable populations.

Psychological First Aid should be initiated by first responders and carried forward by all relevant staff subsequently engaged in the response. Specific formal interventions, such as single session debriefing, should not be provided.

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5   See *Preparing Scotland: Warning and Informing Scotland* and *Preparing Scotland: Warning and Informing Scotland - Using Social Media in Emergencies,* both at www.readyscotland.org/ready-government/preparing-scotland/

During the first week social care and mental health professionals should provide supervision and support for Psychological First Aid providers. They should also plan their responses to people's emerging mental health needs, including the care and treatment of people who develop disorders.

Responders should be aware of the broad spectrum of ways in which people may react psychosocially to an emergency. They should be able to deliver Psychological First Aid and should know how to make referrals for the very small minority of individuals who may need specialised mental health intervention at this stage.

People whose pre-existing mental health problems are exacerbated in the days after an emergency should be referred for specialised mental health intervention.

People should be neither encouraged nor discouraged from giving detailed accounts of their experiences but should be given the opportunity to talk if and when they wish to do so.

Support should be delivered in an empathic and open manner. It should be practical and pragmatic and should provide people with information about possible reactions, how they can help themselves, and where and when to access further help if necessary. Written leaflets should be pitched at a reading age of approximately nine years of age and should be translated for people whose first language is not English.

Responders should be trained to recognise and respond to the needs of children affected by emergencies, whether or not they work with children normally. Reuniting children with a parent or other familiar/trusted adult should be a priority. Responders should begin from the assumption that parents (and carers) are the best placed to support their children and should empower them to do so. Professionals should not work directly with children without the consent of a parent or guardian. They should do so only if there is no familiar and trusted adult who is able to provide the necessary care, for example if the parents' own reactions to the emergency overwhelm their ability to provide effective parenting.

People affected by the emergency may wish to meet with others who have been similarly affected. Practical advice and sensitive support should be offered to facilitate the formation of groups and networks that are able to increase opportunities for self-help and to develop and sustain psychosocial resilience and independence[6].

While promoting mutual support among the people who are affected, responders should have processes for screening people who may pose as professional helpers to protect those affected from incompetent or exploitative behaviour. This should not prevent informal support from relatives and friends.

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6   Guidance on this is available from Disaster Action at http://www.disasteraction.org.uk/leaflets/Bringing_People_Together.pdf

All telephone information lines should include provision to direct people to appropriate psychosocial support. They should be staffed by trained personnel who can provide information and support consistent with the approach of Psychological First Aid and integrated with the broader Care for People and Public Communications strategies.

Pre-prepared websites should be adjusted to the specific circumstances of the emergency and made available online.

The Care for People team should work closely with the Public Communications Group to provide psychosocial advice.

Funerals, memorial services, acts of remembrance and cultural rituals should be planned in conjunction with the people who have been affected.

The managers of rescuers, responders and other staff working with people who are affected by the emergency should be aware of the risk to staff of secondary traumatisation or burnout. Special attention should be paid to staff who are directly affected by the emergency including, for example, staff living and/or working in the affected communities. Support, based on the principles of Psychological First Aid and peer support should be provided for staff who are affected.

4.3 During the first month

Psychosocial and mental health plans and responses should be reviewed and regularly updated based on the specific circumstances of the particular emergency and the emerging needs of the people and staff who are affected. This includes interventions begun earlier in the emergency response that may need to continue or change and psychosocial components of the communications strategy.

Mental health and social care (and, where appropriate, education) professionals should continue to provide advice during the recovery phase and should be involved in reviewing and developing the broader Care for People strategy.

Local Health Board(s) should work with partner agencies and lead on delivering primary mental health care and augmented primary mental health services for people who develop mental disorders as a consequence of emergencies. This may include involving mental health clinicians in a "one-stop shop" model of service provision.

People who have psychosocial problems that do not resolve after adequate humanitarian aid, welfare services and social support from their families and communities should be identified. These adults and children should be formally assessed in terms of their need for health and/or social care services. Assessment should consider people's emotional, social, physical and psychological needs and should take place before any specific intervention is offered.

Appropriately skilled staff from the mental health care services should work with and offer supervision and advice to staff in primary care to develop their knowledge, skills and resilience.

People who develop acute mental health problems in the first weeks after an emergency (e.g. psychotic symptoms or suicidal thoughts) or whose pre-existing mental health problems are exacerbated should be referred for specialist mental health intervention.

The percentage of people affected by an emergency who are likely to develop high levels of distress during the first month after an emergency is low, but they should be identified so that services can maintain contact with them.

Mental health assessments should be undertaken by staff who are skilled and experienced in working with specific populations (e.g. children and adolescents, elderly people). If treatment is considered appropriate, it should aim to promote a sense of safety, calm, self- and community-efficacy, connectedness and hope, as core features before more specialised interventions begin.

In order to identify those at risk of secondary traumatisation or burnout, there should be continued monitoring of staff in responder organisations and other staff working with those affected by the emergency. Special attention should be given to non-professional responders and to those staff living and/or working in the affected communities. Mental health care services should be provided to those who are assessed as requiring them.

4.4 During the first three months

Psychosocial and mental health interventions should continue to be reviewed and updated according to specialist advice and current circumstances.

Where support groups and networks have been established, there should be liaison and consultation with these regarding the delivery of services and planning for future support.

If emergency-specific services have been established to meet the psychosocial and mental health needs of the affected populations, care should be taken to ensure the services remain available to all those affected and are integrated with other community, social and mental health services.

Evidence-based interventions should be made available for adults and children who have developed post-traumatic disorders. Guidance on this is available from the National Institute for Health and Clinical Excellence[7] and NHS Education for Scotland's Guide to delivering evidence-based psychological therapies in Scotland (The Matrix)[8].

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

7   www.nice.org.uk (Anxiety: cg22 / Depression: cg90 / PTSD: cg26 / Substance misuse: cg51)

8   www.nes.scot.nhs.uk/media/425354/psychology_matrix_2011s.pdf

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

Support and information should be made available to the families and friends of people who develop mental disorders with a view to maintaining and enhancing available psychosocial support, while bearing in mind confidentiality and the wishes of the people who have been affected. These are especially important where children and young people are involved.

General information about possible reactions to traumatic events should be made available to schools in the affected communities and to employers (and in particular to occupational health providers) whose staff may have been affected by the emergency.

Where emergencies have involved extensive damage to homes, property or businesses, there may be delays in the resolution of insurance claims or other pressures. In these circumstances people should be offered support by appropriate agencies in keeping with the principles of Psychological First Aid.

4.5 Beyond three months

Psychosocial and mental health interventions should continue to be reviewed and updated according to specialist advice and current circumstances.

Mental health and social care specialists should continue to provide advice to responder organisations until recovery phase responses have been completed.

Professional practitioners should offer formal assessments to people who have psychosocial problems that continue or develop three months or more after an emergency. Assessment should take place before any specific intervention is offered.

Evidence-based interventions should be made available to people who have developed mental disorders as a result of the emergency. Identified staff in specialist mental health care services should be made available to work with and offer supervision and advice to staff in primary and secondary care.

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

It is not uncommon for legal proceedings relating to emergencies to take place several years after the event. These proceedings and their findings, together with any associated media interest, may be a source of further distress for those affected by the emergency and for the wider community. The Care for People team (or its successor) should work with relevant Public Communications Group members to ensure psychosocial advice is provided at such times.

People involved in legal proceedings relating to the emergency should be offered support by appropriate agencies (e.g. Victim Support, Inquest, Criminal Injuries Compensation Authority)[9].

If emergency-specific services have been established to meet people's psychosocial and mental health needs, then they should remain available to everyone who is affected for as long as a need persists.

There should be careful planning before closing any emergency-specific services to avoid giving the message that there is a time limit on the provision of support. The possibility of a phased closure or progressively integrating with other community, social and mental health services should be considered. The nature and circumstances of the particular emergency should determine whether these are appropriate measures.

Local authorities and Health Boards should consider how resources will be made available in the longer-term recovery period to facilitate additional follow-up support, which may extend for several years.

Memorial services, acts of remembrance and cultural rituals marking the anniversaries of the emergency should be planned in conjunction with the people who have been affected. They may want to do this independently or as a group. Some people may require additional support at this time.

An evaluation of the psychosocial and mental health response should be conducted based on consultation with those involved, and any lessons identified should be followed up.

When people have been affected by emergencies there is a likelihood that professionals (e.g. from academia, medical departments etc) may wish to conduct research. Any such requests should be fully and properly considered, and it is recommended that Regional Resilience Partnerships identify a 'Lead for Research' through which any requests may be directed, and whom may coordinate information gathering, research and evaluation programmes. In this context the Lead for Research may best sit with the individual that has, or would be the identified chair of STAC. The Lead for Research should work in consultation with the Caldicott Guardians[10] and other staff who are responsible for information stewardship in the involved agencies.

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9   Guidance on this is provided by a Disaster Action leaflet entitled 'Legal Representation after a Disaster' at:
     http://www.disasteraction.org.uk/support/da_guide12.htm

10 A senior person responsible for protecting the confidentiality of patient and service user information. See
     http://systems.hscic.gov.uk/data/ods/searchtools/caldicott

Annex 1 – Acknowledgements

The guidance has been developed from a wide range of Scottish, UK and international sources of expertise. These sources include work led by the Department of Health for the North Atlantic Treaty Organisation (NATO) Joint Medical Committee and work conducted by the European Network for Traumatic Stress (TENTS) programme. In 2009 the authors of the NATO guidance and the TENTS guidelines combined the common principles and recommendations of both sets of guidance in a single document, *Guidance for Responding to the Psychosocial and Mental Health Needs of People Affected by Disasters or Major Incidents*. This document has formed the basis of the Scottish Government guidance.

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