

Prioritizing Care During the Acute Phase: The Prominent Role of Basic Psychosocial Life Support

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Abbreviations:

15WCDEM = 15th World Congress on Disaster and Emergency Medicine
GHOR = National Medical Emergency Preparedness and Planning Organization (The Netherlands)
TAP = targeted agenda program

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Abstract

The issue of basic psychosocial life support during and after disasters is important. People who are affected by disasters can experience severe distress and may need psychosocial support. However, there still are many questions about service design and effectiveness of psychosocial support.

During the process of the Targeted Agenda Program, "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 programs involving all disciplines and all responsibilities.

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Introduction

When disaster-producing events strike, they often are sudden, unexpected, and "earth-shattering" to those affected. Those who have been 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 studies indicate that these events affect the lives of people for years and even decades. Understanding the effects of these disaster-producing events upon victims' minds, bodies, relationships, and behavior, 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, participated in the 15th World Congress on Disaster and Emergency Medicine 2007 (15WCDEM). Its targeted agenda program (TAP) 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 and recovery. 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 TAP 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-producing event.

Directing and promoting good practice in policy-making with regard to post-disaster psychosocial care requires a clear vision of what constitutes psychosocial care. Some relevant questions required answers:

1. What is the aim of psychosocial care?
2. How should it be delivered? and
3. Who is in need of psychosocial care?

The TAP during 15WCDEM allowed Impact to discuss these questions with other experts in the field of disaster medicine. The process and conclusions of the TAP during 15WCDEM marks an important step towards further integration of psychosocial care into the broad field of disaster relief.

Methods

The overall theme of 15WCDEM was Preparedness: Knowledge, Training, and Networks. One of the interesting features of 15WADEM was the introduction of the TAP-concept. A TAP is an interactive and dynamic instrument to catalyze knowledge gain. Impact's TAP focused on the role of basic psychosocial life support and 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 during the acute phase of a disaster with regards to red, white and blue (fire brigade, ambulance services, police) including defense and volunteers.

After having decided on the topic of the TAP, Impact formulated the following questions:

1. Could the concept of acute psychosocial first aid be considered an important component of the caretaking system, next to life-saving activities?
2. What role could be ascribed to self-reliance and risk communication?
3. Should acute psychological first aid be an integral part of the disaster planning?
4. Should citizens and existing (mental) health infrastructure play an important role during the acute phase? and
5. Does clear risk communication by the appropriate people make a difference, ensuring that acute psychosocial first aid will help create the desired results, and does risk communication provide the citizens with the opportunity to act adequately?

The TAP Website was launched, where the discussion on these questions amongst the experts was to take place. To facilitate the discussion, the experts first were 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, and/or to add new ones. Information and best practices were shared and relevant literature was disseminated.

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 issues for the Website discussion are presented below.

Track 1: Acute Psychosocial First Aid

1. Identifying the level of urgency: What is meant by "acute"?
2. Acute Psychosocial First Aid: Do's and Don'ts;
3. How might this affect rescue workers? and

4. How might this affect the education and training of rescue workers?

Track 2: Civil Participation/Resilience: An Organizational Perspective

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

Track 3: Risk Communication

1. Risk and crisis communication are psychosocial interventions; and
2. Risk and crisis communication are an intrinsic part of acute psychosocial first aid.

During the first day of the Congress, 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 three specific tracks that had been introduced during the Internet discussion period. Questions that were addressed ranged from what to do or not to do during the acute phase, to the role of a member of the public within the disaster field, and to the importance of risk and crisis communication as an important psychosocial life support intervention. The following day, the discussion continued, also stimulated by Congress participants who joined the sessions, which 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 plenary Closing Ceremony of the Congress. These statements embodied 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.

Results

Website Discussions

The following statements were derived from the pre-Congress discussion using the Website.

Track 1: Acute Psychosocial First Aid—The following statements were developed:

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

Track 2: Civil Participation/Resilience: An Organizational Perspective

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

Track 3: Risk Communication

1. 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);
2. Communication means balancing between awareness and fear. Giving information that is reassuring versus creating fear;
3. During 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?);
4. During the post-event phase: communication is most important;
5. Trust is crucial. Do not hide information; and
6. Rumors are everywhere. The media will fill every vacuum. Make deals with the media.

Summary of the Open Sessions and Invitation-Only Session

The following summaries were derived during the face-to-face discussions during the Congress.

Track 1: Acute Psychological First Aid—In the Netherlands, provision of medical assistance during 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 Geneeskundige Hulpverlening bij Ongevallen en Rampen (GHOR) consists of an operational partnership of both medical emergency and psychosocial service organizations. The GHOR is the National Medical Emergency Preparedness and Planning Organization.

Within the national policy, psychological first aid is part of the planned activities during the acute phase and will be considered from the first moment. Since The Netherlands is a relatively low risk country for hazards that may result in disasters, improvements in preparation and expertise have to be based on lessons learned from other countries and published evidence-based guidelines.

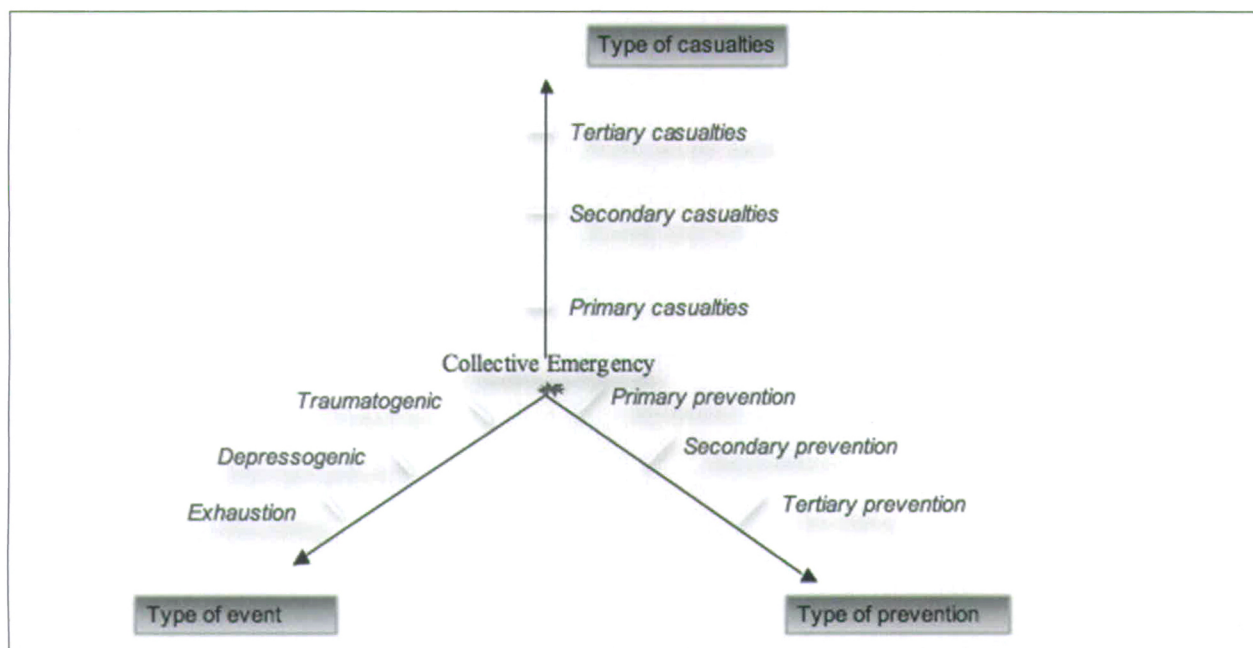
Experiences from other countries have demonstrated that acute psychological support while the disaster still is in

progress (peri-traumatic support) by fire, rescue, and emergency medical personnel is possible. Rescue workers can, and actually do, play a role in providing psychological first aid. On-scene trauma support can take place by getting close to the victim, judging the situation of the victim, looking at the victims' emotional reactions, and assisting them by diverting their attention from pain and experienced life-threat, or, assisting them to concentrate on other things such as controlling their breathing. In Belgium, the Fire Squirrel project—in which specific training is provided to fire or rescue services personnel, named the fire squirrels, in order to enable them to support incarcerated victims in severe motor vehicle crashes—aims to empirically validate these acute trauma support techniques influencing the sense of control, pain perception, perception of life threat, and negative emotions such as extreme anxiety, powerlessness, and horror. These factors also are the most important predictors of long-term traumatization. Other issues about what should or should not be done by first aid and rescue workers needs further research. For example: what can rescue workers offer to family members that are not injured?

A three-dimensional model consisting of type of casualties (primary, secondary, and tertiary casualties), type of prevention (primary, secondary, and tertiary prevention of post-impact sequelae), and type of event can be used to answer these questions with respect to each target group that is in the potential need of psychosocial care. This CRASH model—the Psychosocial Matrix of Crisispsychological Support for the Prevention, Care and Aftercare of Psychological Trauma—is a most suitable tool for emotional and psychological triage. It makes it possible to select the right support techniques and to be carried out by the right people. The CRASH model should be further operationalized as a tool for psychosocial care tailored on the type of the casualties (i.e., psychological triage). 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 (Figure 1).

Also, the debriefing of the rescue workers is important. The psychosocial consequences for rescue workers often are managed by debriefing them after the incident. That the operational debrief phase must 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 >100 injured, the debrief following the train crash was poorly handled with little structure, resulting in anger and frustration. After the 07 July 2005 bombings, lessons had been learned and the feedback from staff was very supportive of the way the post-incident support was managed.

It is recommended that the technical briefing be separated from the emotional debriefing. The focus of the operational debrief should be on practical issues such as preparation, response and lessons for the future. On the other hand, emotional debriefing should be part of the routine early intervention and not only be crisis driven. Research based on the London experiences concluded that proportionality is vital. While 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 sup-



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Figure 1—The psychosocial matrix of crisis-psychological support for the prevention, care and aftercare of psychological trauma (CRASH) model. A three-dimensional model including type of casualty, type of prevention, and type of event
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port or intervention. Only in a minority of cases was more expert help and support required.

Track 2: Civil Participation and Resilience: An Organizational Perspective—Civil participants are first on the scene of an incident, and 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 into the long-term, mental health risks.

Civil participation includes medical aid and psychosocial first aid from the 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.

The questions are: (1) how far should civil participation go?; (2) how can civilians protect themselves from injuries and infections?; and (3) what are the psychosocial consequences, for example, developing post-traumatic stress disorder (PTSD), for civilians involved in the response after a disaster? There are no definitive answers to these questions, but, in general, citizen responses to disaster are largely underestimated in Europe. Citizens are more capable of helping themselves and their fellow citizens during the responses to disasters than official organizations acknowledge. There are three generally held concepts in relation to the reaction of people as a response to a disaster: (1) they will panic; (2) they are helpless; and (3) they are malicious. In fact, none of these three statements 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 provide great psychosocial support for victims—thereby multiplying the usually sparse professional capacity. A paradigm shift

within the governmental organizations 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 what are the consequences for citizens, should be kept in mind and should be answered in time.

Track 3: Risk Communication—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 with 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 actions and information.

Different tools and aspects in the crisis and risk communication form a prerequisite for effective risk and crisis communication. Networks of communicators and other information professionals in emergency management and other related areas are needed. 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.

	Do	Don't
On the Spot (e.g., without freedom of movement)	<ul style="list-style-type: none"> - Care for your own safety - Help other caregivers assess the most urgent needs of the victim - Stay close to the victim - Make contact - See how he/she is - Introduce yourself - Check breathing - Assist the victim in reducing anxiety by calming down breathing - Act of the experienced life-threat anxiety and arousal of the victim - Provide reassurance - Stay calm, do what comes naturally - Be aware of cultural-/religious-specific aspects that may be misleading (e.g., expression of anxiety or pain) 	<ul style="list-style-type: none"> - Make promises or unrealistic expectations - Use words like "pain" or other suffering-related words
Acute Phase	<ul style="list-style-type: none"> - Give information - Make contact with relatives - Stay calm, do what comes naturally - Use resilience and self-reliance 	<ul style="list-style-type: none"> - Provide confidential, incorrect, or irrelevant information - Separate children from their parents or families

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Table 1—Guideline of the dos and don'ts for first responders

Building different formalized 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 following the onset of the event;
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 the 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 always should be taken into account;
8. Psychosocial care during the acute phase primarily is practical and non-medicalizing, and fits to the needs of the victims and specific target groups; and

9. Consensus has been reached about a simple guideline of the do's and don'ts for first responders (Table 1).

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 education 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; and
4. During the acute phase, psychosocial care should be provided in conjunction with standard healthcare 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 well-being and mental health;
3. Communication is about striking the right balance between awareness and fear; and
4. Communication is about key figures gaining trust and credibility and addressing public risk perception and understanding.

Conclusions

The participating expert group has contributed in a important way to promote the prominent role of basic psychosocial support during and after disasters. Experts from different backgrounds have been working together on this topic. Consensus was reached that psychosocial life support can be delivered by first responders with different responsibilities like police, fire-

fighters, ambulance personnel, volunteers, and professionals with a psychological background. Also, citizens and bystanders play an important role in this matter. One of the results of this expert meeting is simple guidelines with do's and don'ts for first responders. The first draft of these guidelines should be tested in practice and evaluated.

The cooperation with the WADEM Board of Directors and its Psychosocial Task Force were inspiring and supportive to the work that was done during the TAP "Prioritizing Care During the Acute Phase: The Prominent Role of Basic Psychosocial Life Support". It is the wish of the authors that this document be used during the next world Congress of the WADEM to further develop the expertise and knowledge of high quality psychosocial care in disaster relief.