London Incident Support Pathway for Adults

Multi-agency support pathway for adults affected by the London Bridge terrorist incident

June 2017

Adult Pathway

1. Introduction

We are indebted to our mental health colleagues across Greater Manchester whose work in developing a systematic response to the attack in their city has provided the main structure to these pathways. They have been extremely generous in sharing their time, expertise and outputs and we would like to express our heartfelt appreciation to them. We are united in our desire to work together to support those affected by attacks on our cities.

This document outlines the support pathway for adults affected by the major incident in London on 3rd June 2017.

The adult support pathway complements the children and young adults (CYP) pathway. It draws on materials produced following the Manchester Arena bombing to ensure that the NHS is consistently following a pathway approach in the provision of support and treatment to those people affected following a major incident.

The incident at London Bridge on 3rd June 2017 was exceptional and able to cause pervasive distress in almost anyone. The circumstances of that night meant that the following groups are at risk of developing Post Traumatic Stress Disorder (PTSD):

- **Victims of the terrorist attack currently receiving immediate physical health treatment;**
- **Family members and friends of the victims of the terrorist attack;**
- **People who witnessed the attack on London Bridge and subsequently in Borough Market;**
- **Members of the public that were in the vicinity of the attack and had to immediately vacate the area;**
- **Those who attended to support as first responders;**
- **Those who worked to provide subsequent care in the hospital settings across London.**

Many individuals involved in a major incident such as that at London Bridge will suffer short-term effects. In most cases distress is transient and not associated with dysfunction or indicative of people developing mental disorders. Some people's distress may last longer and is more incapacitating.

The majority of people do not require access to specialist mental healthcare; although a small proportion may do so. It is important to access the right help at the right time, for example providing a single session of debriefing as a form of treatment is not recommended, nor as an immediate response to incident.

Values and Principles

Unprecedented large-scale traumatic events will have an impact both directly and indirectly, across families, professionals and our diverse communities.

It is important to ensure that we can provide coordinated, accessible information and support to all of those who may be affected.

Most localities and services have already started to respond to the acute impact of the event.

It is important to ensure a coordinated response, visible leadership and accessible, evidence-based support across the region to ensure those affected have access to the right help at the right time.

Key approaches:

- **Acknowledge the importance of anticipated reactions (stress response) to a major incident;**
- **Support people to develop and sustain their resilience; consider the important role of parents and carers or other trusted adults;**
- **Utilise a multi-agency stepped model of care that provides a continuum of care that is holistic;**
- **Ensure approaches are evidence based and proportional, flexible and timely to respond to the emerging phased needs;**
- **Provide clear and consistent messages and communication;**
- **Ensure professionals and staff providing support have access to training, consultation and supervision.**

Phased Based Intervention Strategy

A strategy of sequenced responses that prioritises prevention throughout will not only maximise the inherent resilience of London's communities, but will also minimise the potential adverse effects of more intensive interventions, and make the best use of specialist resources within the system.

Those involved in delivery are set out in appendix 1.

GUIDANCE

Phase 1 Guidance – immediate response first two weeks

Provision of Psychosocial Support - This is launched within the first week of an incident and disseminated through community, primary care and specialist services to ensure adults and children and young people are able to access advice and support as necessary through universal services.

Phase 2 Guidance – Weeks two to four

Provision of Psychosocial and Psychological Support - this may include a range of interventions to assist in managing distress, but again with an emphasis on normalising and psychoeducation. This multi-agency care pathway will support implementation of the Phase 2 Guidance.

Phase 3 Guidance – from four weeks onwards

Provision of Psychological Support - more detailed guidance is available for specialist clinical teams to support the delivery of specialist triage and consultation, mental health assessment and delivery of specialist evidence based interventions.

Whilst individuals may be monitored or assessed after four weeks the majority of people will be resilient and will not require specialist treatment. Therefore interventions will not commence for most adults until 12 weeks has elapsed.

However, a wider and more varied intervention strategy is likely for CYP and may commence before the 12 week time point. This phase will need to be sustained for two-to-three years.

Public Health, Information, Monitoring and Screening Strategy

Lessons from a number of incidents indicate that initiating a wider public health orientated program to disseminate further normalising messages along the time line is an extremely useful strategy to employ as part of the overall intervention plan.

However, every incident has highlighted the importance of collecting data on who this relates to as soon as practically possible following the incident, including establishing data sharing protocols.

The strategy will have discrete components:

1. A continued program of education for the wider public emphasising normalising information and additionally what not to do (i.e. resort to alcohol) and importantly if you need help that it corresponds with guidance issued by the team.
2. Alongside the wider education for high risk cohorts—including first responders and also those who required hospital treatment for injuries on the evening —there will be a need to initiate a monitoring component.
3. Long term monitoring and screening for the wider public in order to avoid prolonged cases of PTSD that are likely to respond to treatment.

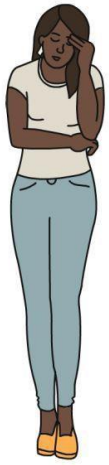
2. Universal Offer – Getting Advice

Who is this for? Adults exposed to the trauma of the events.

Who can deliver it? The various provider organisations across London

What is involved? Self-help advice and normalising

It is common to experience a range of symptoms when exposed to significant trauma. Those symptoms can include:



- **Fear**
- **Helplessness**
- **Increased alertness for danger**
- **Fatigue**
- **Intrusive thoughts or images of the event**
- **Nightmares**
- **Avoidance of places that may remind you of the event**
- **Anger**
- **Anxiety**

All health and social care workers should be aware of the psychological impact of traumatic incidents in their immediate post-incident care of survivors and offer practical, social and emotional support to those involved.

For individuals who have experienced a traumatic event, the systematic provision to that individual alone of brief, single-session interventions (often referred to as debriefing) that focus on the traumatic incident should not be routine practice when delivering services.

Relevant links:

http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/copingafteratraumaticevent.aspx

http://www.nhs.uk/Conditions/Post-traumatic-stress-disorder/Pages/Introduction.aspx

https://www.psychology.org.au/publications/tip_sheets/trauma/

https://www.nice.org.uk/guidance/cg26/informationforpublic

3. Targeted Offer – Getting Help

Getting Help

Who is this for? Adults exposed to the trauma of the events.

Who can deliver it? Various provider organisations across London.

What is involved? Monitoring.

NICE (2005) recommends 'watchful waiting' of up to four weeks following a trauma, before offering an intervention, to allow time for spontaneous recovery, unless there is risk in terms of suicidal ideation/self-harm (see risk support section).

Group debriefing and counselling/therapeutic interventions are not recommended during this time and further supported by the NICE Terrorist Incident Group. Those not directly present but the bereaved should be signposted to information about stages of loss and grief and appropriate agencies.

A number of sufferers with PTSD may recover with no or limited interventions. However, without effective treatment, many people may develop chronic problems over many years.

The severity of the initial traumatic response is a reasonable indicator of the need for early intervention, and treatment should not be withheld in such circumstances.

However, for individuals at high risk of developing PTSD following a major disaster, consideration should be given (by those responsible for coordination of the disaster plan) to the routine use of a brief screening instrument for PTSD at one month after the disaster.

It may be more appropriate to consider a letter to those people who sought treatment on the night of the incident and for this to be sent out at four weeks post incident date as a method demonstrating empathy, reminding people of good self-help techniques but also importance of getting help and how if problems persist.

Introduce Monitoring

Where symptoms are mild and have been present for less than four weeks after the trauma, monitoring as a way of managing the difficulties presented by individual sufferers should be considered by healthcare professionals. A follow-up contact should be arranged within one month.

Targeted monitoring and screening should be considered for high risk groups such as first responders and those people who attended hospital for physical injuries.

Key Approaches

- Identification and monitoring of people at risk;
- Enhanced psychosocial support through community services including: provision of emotional, physical and social support as necessary;
- Promotion of sense of safety (providing reassurance and challenging false negative and anxious ruminations);

- Promotion of calming (psychoeducation regarding stress responses; strategies to support emotional regulation including breathing exercises, progressive muscle relaxation and mindfulness strategies; sleep strategies);
- Promotion of self-efficacy (encouraging and empowering re-engagement in routines and activities);
- Promotion of connectedness (supporting connection with social networks including family and friends);
- Instilling hope (encouraging expectation that a positive future or outcome is possible);
- Provision of support for parents and carers affected;
- Specialist telephone consultation and review of needs.

4. Specialist Offer – Getting More Help

Who is this for? Adults exposed to the trauma of the events where symptoms are present between four and 12 weeks.

Who can deliver it? Local Improving Access to Psychological Therapy Services (IAPT) in the first instance, and Specialist Provider Organisations.

What is involved? Brief psychological interventions (five sessions) may be effective if treatment starts within the first month after the traumatic event. Beyond the first month, the duration of treatment is similar to that for chronic PTSD.

Beyond four Weeks

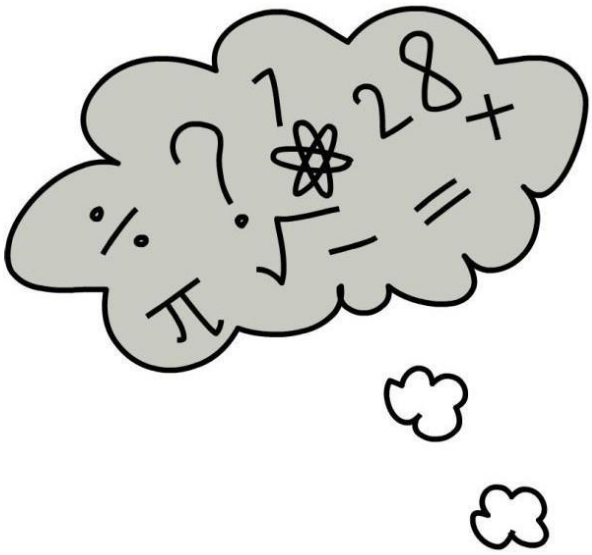
Some individuals will experience symptoms of anxiety, depression, and sleep difficulties which will not reach threshold for trauma focused interventions, it is important to recognise that a stepped care approach will be vital for managing these difficulties.

Trauma-focused cognitive behavioral therapy should be offered to those with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event. These treatments should normally be provided on an individual outpatient basis.

Trauma-focused cognitive behavioral therapy should be offered to people who present with PTSD within three months of a traumatic event.

The duration of trauma-focused cognitive behavioral therapy should normally be eight to 12 sessions, but if the treatment starts in the first month after the event, fewer sessions (about five) may be sufficient.

When the trauma is discussed in the treatment session, longer sessions (for example, 90 minutes) are usually necessary. Treatment should be regular and continuous (usually at least once a week) and should be delivered by the same person.



Consider extending trauma-focused psychological treatment beyond 12 sessions and integrating it into an overall care plan if several problems need to be addressed, particularly:

- after multiple traumatic events
- after traumatic bereavement
- where chronic disability results from the trauma
- when significant comorbid disorders or social problems are present.

If the person finds it difficult to disclose details of the trauma(s), consider devoting several sessions to establishing a trusting therapeutic relationship and emotional stabilisation before addressing the trauma.

Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories.

EMDR often helps people feel better very quickly, but it is important to work through the entire eight-phase process with a qualified EMDR therapist to ensure the most beneficial, lasting results.

EMDR sessions should last for around 90 minutes over eight to 12 sessions.

Staying Safe & High Risk Groups

If there is a high risk of self-harm, concentrate on the management of this risk first and follow established guidance on managing self-harm. This aspect transcends all phases of the pathway.

Some individuals may be at higher risk of developing PTSD than the general population. Risk factors may include:

1. A significant personal history of trauma including developmental trauma, and possibly a previous diagnosis of PTSD;
2. A psychiatric history or a significant family psychiatric history;
3. An absence of a social or supportive network or evidence for significant social isolation;
4. Significant life adversity / stressors post-trauma;
5. Trauma severity and / or dissociative response during event.

These risk factors need to be considered and if an individual is identified in this high risk group, they may need to bypass a stepped care approach and instead be considered for specialist trauma services.

Appendix 1

This sets out the detail and resources to support a stepped model of care to support the needs of adults following the London Bridge Terrorist Incident (including staff training, direct support, and intervention).

AREA OF NEED/ PATHWAY	1. PREVENTATIVE/THRIVING Skilling up members of the public and people who support them	2. EARLY INTERVENTION/GETTING ADVICE Monitoring/Signposting/self-management/one off contact or ongoing support	3. TARGETED SUPPORT/GETTING HELP Goal focussed/evidence-based and outcome focussed interventions	4. SPECIALIST SUPPORT/GETTING MORE HELP Intensive treatment/risk management
Staying Safe **If there is a high risk of self-harm, concentrate on the management of this risk first and follow established guidance on managing self-harm.**				
Trauma-related reactions; including, anxiety, low mood, excessive anger, increased use of alcohol, drug use and other related physical, psychological and/or social difficulties **IF SIGNIFICANT RISK IS EVIDENT AT ANY TIME SEE PURPLE COLUMN 4**	**AIMS: Encouraging those affected by the event to seek and receive the support they need.** **Red Cross emergency app:** Free to download with advice on coping with terrorist attacks and the ability to let loved ones know you're safe Resource for discussing incident with CYP (by **Red Cross**). Tips for Everyday - Living with Stress (by **Mind**): Video Resource on how to deal with Distress (by **Red Cross**). Trauma Information Sheet (by **David Baldwin**). Victim Support Helpline Tel: 0808 1689 111	**Frontline Supporters (including non-specialists)/GPs/Primary Care based support** Encourage people to go to their GPs or health professionals if the distress is acute or continues beyond 2 weeks. Local Humanitarian Assistance Centre; this will operate in the local authority area directly affected by the incident. In this instance information will be available in the corresponding local authority area website. Information on Coping with Trauma and Loss (by **Cruse**) An online self-help website for managing emotions (by **Get Self Help**). Anxiety and Panic Information (by **Mind**).	**4 weeks post-incident consider if trauma-related difficulties might now require specialist support** **PTSD** **Use screening such as Impact of Events Scale – Revised to screen for PTSD (link).** VIII-E_Impact_of_Events_Scale_Revised.p Scores over 33 suggest the possible presence of PTSD **Offer Trauma-Focussed Cognitive Behaviour Therapy (TF-CBT) or Eye Movement Desensitisation and Reprocessing** Available from local IAPT services. **ANXIETY** **Use the Generalised Anxiety Disorder (7)**	**Community Mental Health Teams** If patient presents with complex co-morbidity, extensive previous history of trauma and substance misuse the patient should access their local secondary mental health provider for them to be assessed for signs of enduring problems and referred to specialist services as required. Therapies with a good evidence base are available across London to address need and provide more intensive support. **In cases with significant risk of harm to self:** If significant risk is present the therapies in column 3 should be provided within a community mental health team in secondary mental health services with additional support for managing risk.

	Mind Infoline Tel: 0300 123 3393 Cruse National Helpline Tel: 0808 808 1677 Cruse Bereavement Information. Traumatic Bereavement Information. **Self Help Information on Stress (link):**  Stress - NHS Self-Help Book.pdf	Information on how to support someone to seek help (by **Mind**). **Post trauma symptoms** PTSD: A guide for GPs (link)  Post traumatic Stress A4 2016 FINAL.pd.pc **Worry and anxiety (link)** **Encourage watchful waiting and self help**  Anxiety A4 2016 FINAL.pd.pdf **Symptoms of low mood (link)** Encourage watchful waiting and self help  Depression and Low Mood A4 2016 FINAL **A full suite of resources in accessible and video formats are available online.**	**Questionnaire (link)** Scores greater than 7 indicate clinical anxiety  GAD-7_English.pdf **Offer CBT** Available from local IAPT services **Depression** Use the Patient Health Questionnaire (9) (link)  PHQ-9_English.pdf Scores greater than 9 indicate clinical depression **Offer CBT and Interpersonal Therapy (IPT).** IPT is particularly effective if depression is "loss/bereavement" related If these two treatments are refused or unsuccessful then **offer Counselling for Depression (CfD)** or **Dynamic Interpersonal Therapy (DIT).** At this point, explain to the service user that the evidence for these two therapies is not as strong as that for CBT & IPT If the depression is related to or maintained by a current relationship then offer **Behavioural Couples Therapy for Depression.** All these therapies should be available from local IAPT providers	Office hours: Emergency consultation with local mental health assessment service Out of hours: **General Practitioner** **Local Accident and Emergency Department** **Highly Specialist Trauma Services:** If patient continues to experience significant difficulties, a referral to a highly specialist trauma service should be considered. Access to these services will be via secondary mental health services. London has various highly specialist trauma services information can be found below: **South London and Maudsley NHS Foundation Trust** National Centre for Anxiety Disorders and Trauma 99 Denmark Hill London SE5 8AZ **Traumatic Stress Service,** **South West London & St George's Mental Health NHS Trust** Springfield University Hospital, 61 Glenburnie Road. London SW17 7DJ Tel: 0203 513 6911 **Camden & Islington NHS Foundation Trust** Complex Depression, Anxiety and Trauma Service Camley Building St Pancras way London

				NW1 OPE **East London Foundation Trust** Institute Of Psychotrauma 86 Old Montague Street Whitechapel London E1 5NN **The Tavistock and Portman Trauma Service** Tavistock Centre 120 Belsize Lane London NW3 5BA