Chapter 1

Emergencies, Incidents, Disasters, Disease Outbreaks, and Mental Health

The Scope of This Book

Richard Williams

This Book

This book is about some of the psychosocial aspects of emergencies, incidents, disasters, and disease outbreaks.

My clinical and academic engagement with the mental health consequences of, and responding to emergencies and disasters began when the *Herald of Free Enterprise* capsized in Zeebrugge Harbour on 6 March 1987, causing the deaths of 193 passengers and crew. Many more people survived; some were injured, and the impacts on the mental health of the survivors became a major long-term issue. I learned a huge amount from patients who were referred to me. This incident occurred relatively soon after the American Psychiatric Association had first included post-traumatic stress disorder (PTSD) in its *Diagnostic and Statistical Manual of Mental Disorders (DSM)* in 1980. There have been huge developments in science and practice relating to the mental health aspects of disasters in the 37 years that have elapsed since the Zeebrugge ferry tragedy.

Subsequently, I have had the privilege of being interested in, researching, working directly on, and advising governments and the responsible authorities about their management of a range of incidents and disease outbreaks. This privilege stems from the enormous generosity of people directly affected by what might loosely be termed emergencies and disasters. At the worst moments of their lives, often while they were worried about the survival and whereabouts of close family members, they have allowed me into their lives. Thus I have come to see how people behave in extreme situations, and the truth is very often substantially different from the perceptions of the public, the media, and films. Therefore one motivation for writing this book is the need to provide a balanced account.

I have also met and worked with a great many talented and dedicated people from around the world, whose role is to reduce the impacts of disastrous events on the people who are affected by them. I have worked extensively in the UK and with all four governments there, in the USA, and in Australia and New Zealand.

I have worked through three pandemics. The first was in the 1980s, when I was engaged in advising young people and education authorities on how to cope with the rapid spread of HIV/AIDS. Colleagues and I published a journal paper describing how young people reacted adversely to the stark messages in the UK government's public campaign. This drew me into involvement in creating better educational material that was explicit but also helpful and acceptable to young people. The next few years were quite an experience. Like so many disastrous events, HIV/AIDS raised a number of challenging ethical issues about the nature and content of the advice that people requested, and which might be offered to them. The pop song 'Street Life', which was used to promote the content of the package for young people with which I became associated and which was created in South West England, is still being played! And HIV/AIDS is still a pandemic, despite the huge scientific advances in finding effective treatments for it.

Next was the flu pandemic of 2009–2010, when I was directly involved in developing policy and practice that was intended to protect people in the UK. There were huge and persistent anxieties about the potential impacts of the pandemic on the public, healthcare, and other services, and on the people who deliver them. I very rapidly learned a lot about the relevant public health principles. Again there were great challenges to public ethics. I was involved in working on a fascinating committee that reported to the Cabinet Office and the Department of Health, and which was charged with creating a framework for ethical decision making. That pandemic resolved reasonably rapidly, whereas the next one, in which I am involved now – the pandemic caused by the SARS-CoV-2 virus – has not. What stands out for me about

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the COVID-19 pandemic is the substantial way in which people's socioeconomic circumstances have affected both the risks that they face and the impacts on their psychosocial and mental health.

In all of these circumstances, kindness has come to the fore as an important component of responding, as has the power of families and communities to shape how people cope under duress. Early in the present pandemic, much research focused on the evident primary stressors imposed by dealing with the health effects of the virus, but many other stressors, which we term secondary stressors, are now recognised as major influences on outcomes. If readers wish to see further validation of the social determinants of mental health, they need look no further. This leaves me to speculate about the potential for long-term effects on the mental health of populations that may not be visible for some years yet.

Between the last two pandemics was the Ebola outbreak in West Africa. Again I learned a lot about communities and the impacts on those volunteers who went to Freetown of working in conditions that demanded such rigour in donning, doffing, and working in personal protective equipment. The lasting impacts on the volunteers were substantial. Once more we saw the huge relevance of colleagues, communities, and culture to that event.

I have spent substantial amounts of time since the Manchester Arena bombing in May 2017 working as a member of a group that is researching the mental health impacts on the people involved. Most recently, I have contributed a small amount of indirect input to the work of healthcare practitioners in Ukraine. In scientific terms, this is a very large-scale complex emergency as well as a war. It has caused death, loss, misery, and suffering for so many people, but has also reached out to engage so much of the world. In the midst of the enormity of what is happening, the capacity of people for good is also evident. Again, similar issues emerge from these events despite the fact that they have different origins. The horrific effects of the earthquakes in Turkey and Syria were occurring as our editing this book was drawing to a close. These two most recent large-scale emergencies emphasise the signal importance of the socioeconomic conditions in which people live to virtually all emergencies and incidents.

All of my experiences have left me thinking that there are core principles which, arguably, apply across the many varying types of untoward events with which this volume is concerned. That is why the editors have drawn together the contributions in this book.

Signposting the Sections in This Book

As a consequence of these thoughts, and before the SARS-CoV-2 pandemic began, colleagues and I agreed that we should endeavour to distil what we have learned over the years. We wanted to take a broad approach to searching for common principles, and to add in information and evidence from the pandemic to set alongside our wider experiences with regard to terrorism, conflict, flooding, and earthquakes.

Therefore we commissioned expert authors from a range of disciplines to contribute their learning and wisdom. Much of that material is based on research. High-quality studies are hard to put in hand rapidly and with authority during emergencies and disasters, but many of our contributors have applied considerable ingenuity in doing so. The diversity of topics in this book provides evidence of how broadly the world of disaster healthcare has burgeoned in the last 50 years.

We start, in Section 1, by laying a foundation for all the other sections by including four introductory chapters, followed by eight chapters that deal with a range of powerful generic topics that are raised by many emergencies. Early on, we realised that it was important to agree on definitions of common terms, which experience shows may often be used loosely. Therefore this book includes a glossary of recurring terms. We struggled with a summary term to describe the contents of the book, but settled on *emergencies, incidents, terrorist events, disasters, disease outbreaks and conflicts (EITDDC)*. Part of Chapter 49 covers these terms in more detail. Importantly, Chapter 4 introduces the human element of common emergencies in the UK. The first short account is provided by a woman who was involved in a serious car crash, and the second is by a person who was previously a trainee in pre-hospital emergency medicine. What is very clear from both accounts is that human contact is hugely important to sufferers, their relatives, rescuers, staff of Blue Light services, and healthcare practitioners alike in dealing with extraordinary events.

Section 2 covers two very important sources of impacts – often unpredicted – on the mental health of people who are involved in emergencies and disease outbreaks. Thus in this section we review the massive developments in our capabilities for responding to the

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needs of people injured in emergencies, and the vital importance of realising that civilian and military healthcare practices are linked. We also offer three chapters on the impacts of disease outbreaks. Although not directly about mental health, each of these six chapters is clearly linked to the ways in which people respond to, adapt to, and face the risks of possible mental disorders that arise from being involved directly and indirectly in events that are beyond the majority of everyday experiences.

Section 3 embraces directly the huge contributions made by the social sciences to our understanding of the vital connections of EITDDC with people's social circumstances and relationships. These chapters illustrate the importance of including people's social relationships when designing and delivering responses for them. We learn about the importance to outcomes of the legitimacy with which the public views the emergency services and, in Chapter 22 in particular, of the importance of so-called bystanders to the effectiveness of responses mounted by societies to all untoward events. This might be a hard lesson for our Blue Light services, but we have learned that it is vital that they accommodate the willingness of some members of the public to be involved if our emergency responses are to be maximally effective.

Sections 4 and 5 cover the responses required by the public, and the importance of caring for and supporting the staff of services who respond to EITDDC. The chapters in each of these sections demonstrate the importance of social support that was established by the authors of Chapter 5 and explained in detail in Section 3. They contain a wealth of well-researched material and accounts of actions taken in recent EITDDCs presented as case studies.

In Section 6 the book returns to the importance of effective effective managers and caring leaders in designing and delivering emergency services that are capable of reducing the profiles of mental health consequences. Thus the book establishes the vital legitimacy of including mental health considerations in all plans and through emergency preparedness and responses. Chapter 52, on public ethics, shows how important it is for governments to behave ethically in EITDDC. COVID-19 has been accompanied by a challenging mix of public populism, and social media posts, which have given vast numbers of people a voice, and a distrust of experts that was emerging before the pandemic began. Chapter 52 paints a picture of the challenges and of the need to find a public approach to ethics that can incorporate many viewpoints.

Finally, the editors draw together the major conclusions of the book in Chapter 56 in Section 7 in a future-orientated endeavour to highlight what we see as the core issues in dealing with the mental health aspects of all EITDDC.

At this point I should like to take this opportunity to thank sincerely all of the authors, and especially my colleagues – Verity Kemp, Keith Porter, John Drury, and Tim Healing – for all their wisdom and for the industry that they have brought to this book.

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