Preparing for Disclosure: A Public Health Framework for Paradigm-shifting Revelations

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Unhidden Foundation
Unhidden Inc.

uNHIdden

"Humankind cannot bear very much reality."
T.S. Eliot (Burnt Norton, Four Quartets (1936))

Table of Contents

Foreword - Dr David Whitehouse

Discovering life elsewhere would be an unprecedented event. The ramifications would touch all aspects of civilization.

As this report shows, the news could come several ways. Already we are detecting possible signs of life called biosignatures from the spectra of planets orbiting nearby stars.

While it's doubtful any one observation of these spectral "fingerprints" will lead to a definite verdict, the accumulation of data over years may lead us to conclude the only explanation for them is life. There are other ways life might be found. We may receive a signal, we may see artifacts and we may have an arrival.

What happens next would depend on whether the discovery was distant microbial life or something more advanced. In trying to imagine what we have never encountered we would draw on the images we know. These come from science fiction, which abounds with tales of invasion and less often about peaceful contact. They also come from folk history and supernatural stories. Many believe we have already made contact, that aliens are here and this is being kept from us. I am not one of them, but this belief is testimony to the deep feelings and strong emotions the subject arouses within us.

In my book, The Alien Perspective, I argue we need to talk about aliens because the discovery could be made at any moment. Perhaps whatever conversations we have, we will never truly be ready for the momentous change. But we need to talk before any discovery. As this report, Preparing for Disclosure, stresses, we need a plan, now.

Aliens have never been high on governments' emergency planning. Discussions about what to do in the event of contact have been held up by stigma and ridicule, worsened by sensational treatment on social media.

This report examines how any news of contact might be disseminated, and how people's responses will range from acceptance or indifference, to fear and the deep ontological shock someone experiences when their world has been overturned. Implications of contact will be with us forever. We would be touched in ways we have yet to realise.

This is an authoritative and timely document which sets the benchmark for civil planning. I commend it to you.

David Whitehouse, PhD
Former BBC Science Correspondent; author of 'The Alien Perspective'
May 2026

Executive Summary

In 2010, the UK-based Royal Society concluded that if extra-terrestrial life were ever detected, a coordinated response addressing all the related sensitivities should already be in place. The public health dimension of that response - managing the societal reaction - is one element that has yet to be addressed in any national planning framework. This report attempts to begin filling that gap.

The public health case rests on a straightforward foundation: the potential consequences of paradigm-shifting disclosure scenarios could be significant, the current preparedness gap is substantial, and the cost of preparing unnecessarily is modest relative to the potential cost of failing to do so. These are the conditions under which the precautionary principle applies. uNHIdden takes no position on whether confirmatory information about NHI (non-human intelligence) or UAP currently exists within classified programs. The public health case does not depend on that question being resolved - it rests on the potential scale of population response to credible disclosure, whatever form that disclosure takes. Preparing for disclosure is not about predicting it or promoting fear - it is about ensuring that if it happens, people are not left without support.

A high-impact disclosure scenario could destabilize individuals' most basic assumptions about reality, their place in it and their sense of safety. In this report we refer to this psychological disruption as 'ontological shock'. The term is used as a working label for a class of responses to paradigm-shifting revelations, not as an established clinical category.

The institutional context makes preparedness planning timely. Since 2017, Unidentified Anomalous Phenomena - UAP, the term that has largely replaced 'UFOs' in official usage - have moved from the margins of public life into the mainstream of institutional attention. The United States has held Congressional hearings, established the All-domain Anomaly Resolution Office (AARO) within the Department of Defense and introduced legislation including the UAP Disclosure Act. In February 2026, President Trump directed the Pentagon and other federal agencies to begin identifying and releasing government files on UAP and related subjects, including materials connected to "alien and extraterrestrial life." Taken together, the breadth of serious institutional attention now being paid to this topic means that disclosure of some form of paradigm-shifting revelation can no longer be treated as too improbable to warrant preparedness planning.

The Health Needs Assessment

The starting point is to conduct a Health Needs Assessment (HNA), which is a systematic method for reviewing the health issues facing a population. A HNA conducted by uNHIdden identified four population groups facing elevated risk in a UAP disclosure scenario, using the UK as a case study. Together, these groups account for approximately 35% of the UK adult population. Applying planning ranges drawn from scenario-bounding literature to this high-risk population produces a stress-test figure - not a demand forecast - of between 3.5% and 10.6% of the adult population who might benefit from some form of psychosocial support following a significant disclosure event. Even at the lower bound of this planning range, the additional demand would be equivalent to 37% of annual NHS mental health referrals in

England; at the upper bound, 110% - figures that illustrate why preparedness planning is warranted, not predictions of the most likely outcome. While direct transposition to the U.S. is not straightforward, the absence of preparedness planning in the U.S. context is at least as significant a gap as the one identified in the UK.

Theory of Change

Given the complexity of the challenge - spanning clinical services, public communication, professional training and community resilience - the report adopts a Theory of Change (ToC) approach, working backwards from the desired end state to the sequence of activities needed to get there. In this context, it organizes preparedness activities into four categories:

A. Facilitative actions that create the system-level conditions necessary for the rest of the activities to be possible.
B. Shifting the mean - building population-level resilience through public education, narrative framing and targeted group work.
C. Surge readiness - building response capacity pre-disclosure so that it can be activated when it is required.
D. Recovery - sustaining support and rebuilding trust over the medium term.

Sections 6, 7 and 8 of the report set out how these four categories translate into specific interventions that include stigma reduction, targeted resilience-building for each high-risk group and a four-layer surge response spanning self-help resources, community support, practitioner readiness and mental health triage. Underpinning this is a communications strategy that recognizes that false information can travel faster than the truth.

Building the coalition

The Public Health Framework is designed to build capability in stages. Four actions are foundational in the near term: a funded research program defining the evidence base for ontological resilience interventions; a simulation exercise with at least one credible institutional co-organizer; a cross-sector conference at which workstream leads are identified and the coalition becomes real rather than aspirational; and at least one government or professional body having formally engaged with the question of disclosure preparedness and committed to further consideration. The full program – spanning stigma reduction, community resilience infrastructure, practitioner training, trusted voice networks and mental health triage – is set out in Section 9.

The success of the framework will be measured by whether - if high-impact disclosure occurs - the population is meaningfully better prepared than it would otherwise have been. The capabilities it requires have value well beyond UAP disclosure scenarios: improved public communication under uncertainty, stronger community resilience, better mental health integration into emergency preparedness. This is an investment in general resilience infrastructure, and one that society should make.

1. Introduction

1.1 Purpose and scope

In 2010, the UK-based Royal Society convened a two-day Discussion Meeting on the detection of extraterrestrial life and the consequences for science and society. The subsequent paper (Dominik and Zarnecki, 2011) [1] concluded that "if extra-terrestrial life happens to be detected, a coordinated response that takes into account all the related sensitivities should already be in place." The public health dimension of that response - managing the societal reaction - is one element that has yet to be addressed in any national planning framework. This report attempts to begin filling that gap.

Since 2017, Unidentified Anomalous Phenomena - UAP, the term that has largely replaced 'UFOs' in official usage - have moved from the margins of public life into the mainstream of institutional attention, particularly in the United States. Congressional hearings have taken sworn testimony from military personnel and intelligence officials; the New York Times investigation that first brought the Pentagon's UAP program to widespread public attention [2] was followed by successive official intelligence community assessments; [3] the All-domain Anomaly Resolution Office (AARO) has been established within the Department of Defense; and legislation, including the UAP Disclosure Act, has advanced the case for systematic transparency.

In February 2026, President Trump directed the Pentagon and other federal agencies to begin identifying and releasing government files on UAP and related subjects, including materials connected to "alien and extraterrestrial life" – a directive issued in the same week that former President Obama's remarks about extraterrestrial life on a podcast generated significant public attention. [4,5]

The institutional shift is not confined to government. A 2026 paper by Deloitte Switzerland, applying a multi-domain risk framework to scenarios that conventional planning tools tend to overlook, uses NHI/UAP disclosure as a substantive case study – noting potential cascade effects across social stability and institutional trust. [6]

Taken together, the breadth of serious institutional attention now being paid to this topic means that disclosure of some form of paradigm-shifting revelation can no longer be treated as too improbable to warrant preparedness planning.

Unhidden Foundation (UK) and Unhidden Inc. (U.S.) (collectively, 'uNHIdden') takes no position on whether confirmatory information about NHI or UAP currently exists within classified programs, nor does this report depend on that question being resolved. Our case rests on a more straightforward foundation: the public health consequences of paradigm-shifting disclosure scenarios could be significant, the current preparedness gap is substantial and the cost of preparing unnecessarily is modest relative to the potential cost of failing to do so. These are the conditions under which the precautionary principle applies. [7] Disclosure has been called the ultimate Black Swan event - a category of rare, high-impact occurrences that are not anticipated by conventional planning frameworks precisely because they fall

outside prior experience. Such scenarios are notoriously difficult to plan for. Yet that makes it all the more important to try.

This report addresses disclosure scenarios ranging from the detection of microbial biosignatures to confirmation of proximate non-human intelligence, applying established public health frameworks - drawing on pandemic preparedness, disaster mental health and crisis communication - to the challenge of population-scale psychological preparedness. Section 1.2 sets out the case for this approach in full.

1.2 Why a public health approach?

The potential scale of impact from disclosure places it beyond the reach of any purely clinical response. Individual therapists, general practitioners, and mental health services - however well resourced - cannot address a challenge that could plausibly affect large numbers of people simultaneously across every demographic, geography and walk of life (including health service workers themselves). What may be required, if high-impact disclosure scenarios materialize, is a public health framework designed to operate at population scale, capable of coordinating responses across multiple sectors and experienced in protecting the most vulnerable while supporting the many.

Public health has been defined as 'the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society' - a formulation widely attributed to the American public health pioneer Charles-Edward Winslow, and one consistent with the foundational principles of the World Health Organization. [8] Unlike clinical medicine, which focuses on the individual patient, public health operates at the level of communities, populations and nations. It brings together surveillance, health promotion, preventive intervention, emergency preparedness and the coordination of care systems.

A foundational principle of public health - articulated most clearly by the British epidemiologist Geoffrey Rose - is that the distribution of risk across a population matters as much as the management of high-risk individuals within it. Rose's insight was that a large number of people exposed to a small risk will generate more cases of harm in aggregate than a small number of people exposed to a high risk. [9] The practical implication is that interventions operating across the whole population - shifting the average level of resilience upward, even modestly - will often produce greater aggregate benefit than concentrating equivalent resources exclusively on those most severely affected. Applied to disclosure preparedness, this means the framework must operate on two levels simultaneously: building population-wide ontological resilience before any disclosure event occurs and ensuring that surge capacity exists to support those most severely affected when it does. These two functions correspond to Sections 7 and 8 of this report respectively, and the tension between them - universal intervention versus targeted response - runs through every design decision in the preparedness framework.

Public health also brings an established equity lens. Major emergencies do not affect everyone equally - disadvantaged communities typically experience disproportionate impact and

slower recovery, as events from the Fukushima disaster to the COVID-19 pandemic have demonstrated. [10,11,12] An effective disclosure preparedness plan should be designed from the outset to reach those least able to seek help unaided.

Perhaps most importantly for this context, public health is experienced in acting under uncertainty. The precautionary principle - given its most widely cited formulation in Principle 15 of the 1992 Rio Declaration on Environment and Development [7] and developed further in European Commission guidance [13] - holds that when an action raises threats of harm to human health, precautionary measures should be taken even if cause-and-effect relationships are not yet fully established scientifically. Pandemic preparedness plans are developed and maintained for threats that may never materialize in their anticipated form. Disclosure preparedness is precisely this kind of problem - and public health is the framework built to address it.

1.3 The dual purpose of this report

This report serves a dual purpose. It is both a review of the evidence base relevant to disclosure preparedness and a practical framework for action.

Readers - whether government officials, public health planners, health commissioners, local resilience leads, third-party organizations, or academics - are invited to respond with challenge, critique and contribution. uNHIdden is convening a conference to bring together institutional, academic and community stakeholders to stress-test this analysis, identify which organizations are willing to take the lead with the various workstreams and begin building a coalition without which a program of this scope cannot be delivered.

This framework is explicitly designed to complement, not replace, existing public health and emergency response systems. It assumes that any coordinated response to high-impact disclosure would be led through established national and international structures - the World Health Organization, the U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration (SAMHSA), NHS England, the UK Health Security Agency and their equivalents - and seeks only to address a currently unfilled dimension within those systems. Note that in certain disclosure scenarios - particularly those originating from defense or intelligence contexts – the initial response architecture may be led by defense and intelligence structures, with health agencies assuming the primary coordinating role as the response matures. This framework is designed to operate within that sequencing.

1.4 Methodology and the Ontological Security Advisory Group

This report was developed through three complementary strands of work.

The first is a synthesis of public health best practice. We reviewed established frameworks for public health emergency preparedness - including pandemic preparedness, disaster mental health and mass casualty response - to identify transferable principles relevant to disclosure preparedness.

The second strand is a focused literature review covering ontological shock and societal resilience. We examined the psychological and social science evidence related to the way individuals and communities respond when their fundamental assumptions about reality are disrupted - drawing on research into trauma, meaning-making, post-traumatic growth and the sociology of paradigm-shifting events. [14,15]

The third strand is critique and deliberation by the Ontological Security Advisory Group (OSAG), established by uNHIdden to guide preparedness planning for disruptive or paradigm-shifting discoveries and the development of this report. The OSAG brings together academics and clinical practitioners across a range of disciplines - including academic and clinical psychology, theology, medicine, general practice and the social sciences: [16]

Alexander Wendt, PhD
Andrew M. Davis, PhD
Brenda Denzler, PhD
Gabriel G. De la Torre, PhD
John Elliott, PhD
Martin Abbas, MBBS MRCGP PGCME
Tim Lomas, PhD

Members of the OSAG have contributed to the academic literature cited in this report. Where this is the case, the relevant citations are noted; readers should be aware of this overlap when assessing those references.

The report has additionally been reviewed and approved by uNHIdden's Medical Advisory Board, comprising doctors and clinical psychologists.

Two important limitations apply across all three strands. First, this report works from indirect and analogous evidence: to the extent of our knowledge, no public health preparedness plan for disclosure has previously been developed and no disclosure event has occurred against which interventions could be empirically tested. We have been explicit throughout this report about where we are drawing upon established evidence, where we are extrapolating from analogous situations, and where genuine uncertainty remains. Second, the quality of evidence reviewed varies substantially. We have sought to signal this variation throughout, distinguishing theoretical frameworks with strong empirical grounding from those where the application to disclosure is interpretive or speculative. Consistent with the precautionary principle, we consider uncertainty a reason for greater urgency in preparedness, not less.

1.5 Companion documents and prior work

This report should be read alongside two companion documents published by uNHIdden: (i) the Health Needs Assessment (HNA), which systematically identifies vulnerable populations and quantifies the potential scale of support requirements; and (ii) a companion academic paper - Priestland, De la Torre and Lomas (2026) [17] - available as a preprint at https://www.preprints.org/manuscript/202605.1417 and which examines the methodology and findings of that assessment against the broader scientific literature.

This report also builds directly upon uNHIdden's earlier work, including our 2024 White Paper on the mental health impacts of exceptional experiences [18] and our 2025 report on the physical and physiological health effects of exposure to UAP. [19]

This report deliberately does not address the consequences of disclosure beyond public health - for example, issues around national or global security, supply chain resilience and financial stability. These are covered elsewhere: for example, the financial consequences of disclosure are covered in Helen McCaw's Sol White Paper [20].

Note: This report is written in American English in accordance with the conventions of its primary target readership.

2. Public health context

2.1 What is Public Health Emergency Preparedness?

Public Health Emergency Preparedness (PHEP) - referred to in the United Kingdom as Emergency Preparedness, Resilience and Response (EPRR) - is the capacity of individuals, communities and health systems to prevent, protect against, respond to and recover from the health consequences of emergencies and disasters. It is a well-established discipline with mature frameworks, institutional infrastructure and accumulated practical experience across governments and international bodies worldwide.

At its core, PHEP rests on a simple but powerful insight: the time to prepare for an emergency is before it happens. Reactive responses - however well intentioned - are invariably slower, more expensive and less effective than those built on prior planning, trained workforces, tested systems and informed populations. This is why governments invest in preparedness frameworks for threats that may never fully materialize in their anticipated form, and why simulation exercises are conducted against scenarios that may prove inaccurate in their specifics.

PHEP frameworks are organized around a preparedness-response-recovery cycle. Preparedness encompasses the planning, training, infrastructure-building and communication work done in advance of an emergency. Response covers the immediate and short-term actions taken once an event occurs. Recovery addresses the longer-term work of restoring and sustaining population health and wellbeing in the aftermath. This three-phase structure is reflected in the architecture of this report.

These frameworks are well established internationally. The World Health Organization's International Health Regulations provide the global legal framework for managing public health emergencies of international concern. [21] In the United States - where disclosure is most likely to originate - FEMA's National Response Framework establishes multi-agency coordination, tiered response and explicit planning for surge capacity; [22] the Centers for Disease Control and Prevention's Public Health Emergency Preparedness and Response Capabilities set national standards for state and local health authority preparedness across fifteen capability domains; [23] and the Substance Abuse and Mental Health Services Administration (SAMHSA) has developed specific frameworks for disaster behavioral health response. [24] In the United Kingdom, the Civil Contingencies Act 2004 and the National Security Risk Assessment (NSRA) provide equivalent foundations, with NHS England and the UK Health Security Agency holding primary operational responsibilities. [25] Across all these frameworks, common elements recur: multi-agency coordination, clear roles and responsibilities, tiered response levels and explicit planning for surge capacity.

These frameworks have been stress-tested through experience. The COVID-19 pandemic demonstrated both the strengths of coordinated public health response and the costs of underinvesting in mental health preparedness. Simulation exercises - including Exercise Cygnus in the UK [26] and Crimson Contagion in the United States [27] - have repeatedly identified preparedness gaps that are far cheaper to address prospectively than retrospectively.

The lessons from those exercises inform the simulation action proposed in Section 6.3. PHEP frameworks have been applied to infectious disease, natural disasters, chemical and radiological emergencies and mass casualty events. They have not previously been applied systematically to a threat that is primarily psychological and ontological in nature - by which we mean a threat whose primary mechanism of population harm is not physical injury or service disruption, but the distress, disorientation and system disruption that follow from a fundamental challenge to established frameworks of meaning. That is the gap this report aims to begin addressing.

2.2 Lessons from comparable events

No previous public health emergency maps perfectly onto NHI/UAP disclosure. The challenge is genuinely novel in important respects - and we address those differences directly in Section 3. But comparable events offer transferable lessons that should inform any preparedness framework.

Lessons from large-scale emergencies

These prior frameworks share a common organizing logic, noted by Zhao and colleagues: resilient health systems require sustained foundational investment – in governance, workforce, and community capacity – before crises occur, so that detection and response functions can operate effectively when they are needed. [28,29]

COVID-19 demonstrated both the strengths and limitations of population-scale public health response. Governance structures could be rapidly mobilized and communication campaigns deployed on a national and international scale. But the pandemic also revealed a persistent failure: effects on mental health were not properly addressed due to inadequate proactive planning. Despite being designated an essential service, mental health provisions were overwhelmed, with the psychological impacts of isolation, bereavement, economic disruption and sustained uncertainty generating elevated rates of anxiety, depression and trauma across multiple countries that existing services lacked the resources to address. [10] The lesson for UAP/NHI disclosure preparedness is direct: mental health planning must be proactive and embedded from the outset, not retrofitted once demand has already exceeded capacity.

Fukushima offers a different but important lesson. The 2011 nuclear disaster required a public health response that addressed both the physical consequences of radiation exposure and significant and lasting psychological distress generated by displacement and inconsistent official communication. Ohtsuru and colleagues [11] and Hasegawa and colleagues [12] document a complex picture: physical health effects, while real, were more limited than initially feared in some domains; but elevated rates of anxiety, PTSD and depression persisted in affected communities for years. The relevant lesson for disclosure preparedness is that an event involving perceived institutional failure or revision of official accounts can generate psychological harm that persists beyond, and sometimes exceeds, the primary physical threat. The implications for government communications strategies are explored in Sections 3.2 and 8.3.

Across these and other major emergencies - Hurricane Katrina, the September 2001 attacks, the Tohoku earthquake and tsunami and Grenfell Tower in London - a consistent set of lessons emerges: early, proactive mental health planning prevents later crises; community-level support networks matter as much as formal healthcare services; disadvantaged populations experience disproportionate impact and require proportionately greater support; and pre-existing social cohesion and trust in institutions are among the most powerful protective factors available.

The limits of conventional frameworks: the ontological dimension

Conventional frameworks are well suited to threats that operate primarily through physical danger, disruption to services or infectious transmission. They are less well equipped for a different kind of threat - one that operates through the disruption of individuals' fundamental assumptions about reality itself. The remainder of this report attempts to supply the additional thinking that established frameworks alone cannot provide.

2.3 Health Needs Assessment methodology

Understanding how to respond to disclosure first requires an appreciation of who may be affected, in what ways and at what scale. A Health Needs Assessment (HNA) provides the systematic methodology for approaching these questions - and it is the analytical foundation upon which the preparedness framework in this report is built.

A HNA is an established public health methodology for identifying the health issues facing a defined population, assessing their relative scale and severity and determining what interventions are likely to be effective and acceptable in response. The approach adopted in this report follows the five-step framework set out in Health Development Agency practitioner guidance [30], with comparable approaches in the United States under the Centers for Disease Control and Prevention Community Health Assessment framework [31]: (i) getting started; (ii) identifying health priorities; (iii) assessing priorities for action; (iv) planning for change; and (v) moving on and reviewing.

The HNA methodology is well-suited to UAP/NHI disclosure preparedness for several reasons. It is explicitly designed for situations in which the evidence base is incomplete and planning must proceed under uncertainty. It is population-focused rather than clinically focused, enabling differential vulnerability analysis. It is also action-oriented, linking needs identification directly to intervention planning and resource allocation. Section 4 of this report summarizes the key findings of the HNA that uNHIdden has prepared for disclosure, along with the implications for preparedness planning.

2.4 Public health and national risk assessment

In the United Kingdom, the National Security Risk Assessment (NSRA) is the Government's assessment of the most significant risks facing the country. It is produced by the Cabinet Office Resilience Directorate and informs plans to mitigate those risks at national and local levels.

[32] The NSRA already incorporates a range of public health risks within its framework - including emerging infectious disease outbreaks, chemical and radiological incidents and mass casualty events - recognizing that health threats can generate population-scale harm requiring coordinated cross-government response. [32]

The NSRA methodology was subject to an independent review by the Royal Academy of Engineering in 2021, which proposed seven principles for good practice in risk assessment. Two of these principles are particularly relevant to the present report. First, the review recommended a shift from likelihood-driven to impact-driven risk assessment - placing greater weight on the magnitude of potential harm than on estimates of probability, particularly for low-probability, high-consequence scenarios. Second, it recommended that risks be reviewed based on need, rather than on a fixed time interval, to ensure that the risk register keeps pace with rapidly evolving threat landscapes. [33] Both principles directly support the case for considering the public mental health consequences of paradigm-shifting revelations within the NSRA framework: the potential impact is substantial even if the probability is uncertain, and the pace of change in the institutional disclosure environment has been rapid.

Correspondence with the Cabinet Office National Risks team, received by uNHIdden in November 2025, confirmed that the UK Government continues to evolve the NSRA methodology in line with the Royal Academy of Engineering recommendations and has committed in its Resilience Action Plan to keep pace with the changing risk landscape. [34] uNHIdden encourages the Cabinet Office to consider whether disclosure preparedness warrants scoping as an emerging risk under these criteria.

In the United States, FEMA's National Response Framework establishes the overarching preparedness and response architecture at both state and federal levels. [22] To our knowledge, neither this framework nor associated planning processes currently include psychological or ontological public health consequences of paradigm-shifting revelations. Given that any disclosure is most likely to occur initially in the United States, we consider this an equivalent and equally important gap to the one identified in the UK NSRA context.

3. Why disclosure is different: unique challenges and considerations

The public health frameworks reviewed in Section 2 provide essential foundations for disclosure preparedness. But disclosure is not simply another emergency to which those frameworks can be applied without adaptation. It presents challenges that differ from previous public health emergencies not merely in degree but in kind. This section examines four dimensions of that difference:

1. the nature of what this report terms 'ontological shock' - used here as a working label for a class of psychological responses to paradigm-shifting revelations, not as an established clinical category;
2. the public trust crisis that potential governmental concealment may have created or may create;
3. the difficulty of controlling information in a networked world; and
4. the particular psychological burden of confronting the possibility of threat.

Understanding these differences is necessary before any preparedness plan can be adequately designed - and each has direct implications for the interventions described in Sections 6, 7 and 8. Throughout this section, confirmation of intelligent non-human presence on or near Earth - Scenario 3 in the Health Needs Assessment - is used as the most demanding planning stress test, not as a predicted outcome.

3.1 Ontological shock

Every previous public health emergency, however catastrophic, has occurred within an intact framework of reality. Earthquakes, pandemics, wars, industrial disasters - however devastating - happen in a world whose basic nature remains understood. The world after the event is recognizably continuous with the world before it: diminished and damaged but not fundamentally altered in its character.

In high-impact disclosure scenarios, this continuity could not be assumed. If it were confirmed that humanity is not alone - and potentially not the apex form of intelligence - the challenge would not be an event occurring within an established understanding of reality. Rather, it could be a discovery that the prevailing framework through which most people interpret reality is fundamentally incomplete. The disorientation that follows - across worldview, identity and perceived safety - is what this report means by 'ontological shock.'

R. D. Laing introduced 'ontological security' to describe the stable sense of being in the world that grounds psychological functioning. [35] Anthony Giddens extended this sociologically, identifying it as the sense of order and continuity that enables people to navigate daily life without existential anxiety. [36] Professor John Mack - a Harvard psychiatrist and Pulitzer Prize-winning author whose clinical work with individuals reporting anomalous encounters remains among the most extensive in the field - applied the concept directly to those confronting the possibility of a non-human encounter, arguing that it was the ontological challenge that most needed integration. [37]

The political dimensions of this challenge have been examined by Wendt and Duvall, who argue that modern sovereignty is constituted on anthropocentric foundations - organized exclusively by reference to human beings - and that this structural assumption produces a systematic institutional incapacity to engage seriously with the possibility of non-human intelligence [38]. The UFO taboo, by their argument, is not irrational but structurally necessary: acknowledging the possibility would threaten the foundations of modern rule itself. This provides an important complement to the psychological account of ontological shock: the disorientation that individuals experience at the point of disclosure has a precise parallel at the level of the state - and the state may be no better equipped to manage it.

In high-impact disclosure scenarios, psychological responses would be expected to operate through two distinct dimensions, each with different intervention implications. The first - the ontological dimension - concerns threats to worldview coherence and life meaning: for someone with a deeply held religious framework, disclosure may challenge theological assumptions about creation and humanity's unique status; for a NHI/UAP experiencer (i.e. someone reporting prior anomalous encounters potentially attributed to non-human intelligence), it may simultaneously validate their prior encounters and force a reckoning with what those encounters implied. The second - the safety dimension - concerns perceived threats to physical security and daily functioning: will NHI entities prove benign, indifferent or hostile? Can governments protect their citizens? These two dimensions are used as the primary axes for vulnerability assessment in Section 4, and the distinction between them is operationally significant: different population groups are vulnerable on different dimensions, and the interventions indicated differ accordingly.

Research suggests population responses would not be uniform. Analysis of social media responses to U.S. Congressional hearings about UAP in July 2023 found reactions ranging from anxiety and conspiracy theorizing to scientific excitement and philosophical reflection, although the study analyzed online discourse rather than population psychology directly. [39] Post-traumatic growth research demonstrates that challenges to core beliefs, while initially destabilizing, can lead to positive psychological change for some individuals. [15] Terror management theory - drawing on the work of Ernest Becker, the interdisciplinary cultural theorist whose analysis of mortality and human behavior remains widely cited [40] - suggests that confrontation with the limits of human significance could activate defensive reinforcement of existing worldviews and rejection of challenging perspectives. Any preparedness framework must be calibrated to the full range of possible responses across populations, from severe distress to constructive engagement.

3.2 The loss of trust in governments

In scenarios where disclosure involves revision of prior official accounts, the most psychologically significant dimension may not be the revelation itself but the perceived secrecy that preceded it. If it emerges that governments, particularly in the United States, have possessed knowledge of NHI and UAP for decades and withheld it from the public, the consequences for institutional trust could be at least as damaging as the disruption of the disclosure itself. As noted in Section 1.1, uNHIdden takes no position on whether such concealment has occurred - but the preparedness implications of this scenario are significant regardless.

Smith and Freyd's framework of institutional betrayal - extending Freyd's foundational betrayal trauma theory [41] to organizational and governmental contexts - offers a plausible account of why the trust dimension of disclosure may prove more psychologically significant than the ontological revelation itself, particularly in light of the nature of government communication on the subject (including, in documented cases, denial, ridicule and stigma [43, and see Section 3.1]). [42] The core insight is that it is not the underlying harm but the violation of a trusted relationship that tends to produce the most severe and lasting psychological damage.

A second factor could compound this challenge in certain disclosure scenarios. If governments were to confirm the existence of NHI, they would confront a set of questions they may be unable to answer: How long have they been here? What do they want? Are they benign? Can governments protect their citizens? The absence of satisfactory answers - particularly for populations accustomed to governments providing authoritative guidance in emergencies - could expose the limits of the social covenant in real time. In scenarios involving prior concealment, that trust may already be damaged before any response begins. The practical implication is that trust infrastructure cannot be improvised at the point of crisis: it must be built in advance, through community-rooted, transparent and multi-stakeholder approaches that do not depend on governmental authority alone.

Wendt has extended this analysis to argue that disclosure could trigger what he terms an 'autoimmune reaction' - a process in which it is not NHI that poses the primary threat, but human responses to the perception of it. The analogy is not a clinical one: Wendt's point is that the destabilizing cascade - institutional defensiveness, competing governmental narratives, collapse of anthropocentric sovereignty from within - is set in motion by the belief that NHI exist, regardless of whether they do. The existence of NHI is not a precondition for the harm; the perception of its existence is sufficient. [44, 45] This has direct implications for preparedness planning: the public health case for intervention does not rest on any particular view of what UAP are, but on the population-scale consequences of a credible disclosure event - consequences that would follow whether the underlying claim proved true or not.

3.3 The difficulty of controlling information

In 2010, Richard Dolan and Bryce Zabel published a speculative analysis of the immediate aftermath of confirmed UAP disclosure that anticipated many of the challenges that governments would face, including those related to information management. [46] Their analysis was produced before smartphones achieved ubiquity, before COVID-19 demonstrated how rapidly misinformation can propagate through social networks and before the current algorithmic media landscape had fully formed. Many of its assumptions about governmental capacity to manage the information environment would need substantial updating for the world as it now exists.

[1] In a 1997 press conference responding to the Phoenix Lights mass sighting - one of the most widely witnessed UAP events in U.S. history – Governor Symington produced his chief of staff dressed in an alien costume, a response he later publicly described as a mistake. See [43].

In high-impact disclosure scenarios, a major revelation - confirmed NHI presence on or near Earth, to take the most demanding case - would likely be distributed globally within minutes. Governments would have essentially no capacity to control the information flow, to sequence revelations at a pace that allowed public adaptation or to prevent speculation and misinformation from occupying the information space ahead of authoritative communication. This is not merely a logistical observation, it has direct implications for the psychological harm that could follow from poorly managed disclosure.

The MIT Media Lab's landmark 2018 study by Vosoughi, Roy and Aral analyzed 126,000 verified news stories shared by approximately 3 million people on Twitter between 2006 and 2017. It found that false news traveled significantly further, more quickly, more deeply and more broadly than true news across every category of information. [47] Critically, this effect was driven primarily by humans rather than automated bots and was associated with the greater novelty and emotional charge of false information. The study was conducted on a single platform, is now relatively old and its findings may not generalize identically across all social media environments; nonetheless, its scale and methodological rigor make it the most robust available evidence on differential diffusion of true and false information. In a disclosure context - where official information would inevitably be incomplete, contested and highly charged - these dynamics would be compounded by a pre-existing UAP misinformation ecosystem that would be massively amplified by any official confirmation.

A further complication applies specifically to the UAP domain. The Vosoughi et al framework assumes that the categories of true and false information are reasonably stable. In a disclosure context, that assumption may not hold: official accounts that have been regarded as authoritative have subsequently been revised or contradicted, and populations with long experience of that pattern may be slower to accept corrections from the same institutional sources. This does not undermine the study's core finding about differential diffusion, but it does complicate the communications response - the counter-misinformation architecture described in Section 8.3 must account for the possibility that some of what circulates as misinformation may, in time, prove partially accurate.

The implications for preparedness planning are significant. Communications strategies cannot be designed around an assumption of controlled, sequenced information release. They must instead be designed for an environment of information complexity in which authoritative voices compete with an overwhelming volume of speculation, conspiracy and misinformation from the first moments. This requires pre-established trusted communication channels, pre-developed messaging frameworks and pre-positioned credible voices - precisely the elements that current preparedness lacks and that the communications readiness strategy in Section 8.3 is designed to supply.

3.4 The possibility of threat

Much public and governmental discussion of the UAP topic has focused on the technological and geopolitical dimensions, treating the subject largely as an abstract strategic problem.

The psychological aspects of disclosure preparedness require engagement with the full range of what might be disclosed - from the relatively benign to the genuinely alarming. Preparedness planning cannot be built on the assumption of a favorable outcome: what if some of what is disclosed is genuinely alarming?

The range of possible disclosure scenarios is broad. At one end, confirmed detection of a biosignature that is both distant and basic in nature - such as evidence of microbial life elsewhere on a distant exoplanet - would be profound but would carry no immediate public safety implications. At the other end, confirmation of proximate NHI presence accompanied by evidence of harmful interactions with humans would present a qualitatively different psychological challenge. For populations simultaneously processing the disruption of the revelation itself, evidence of potential harm would substantially compound the psychological burden. The Health Needs Assessment in Section 4 reflects this spectrum through its three scenarios; the more demanding end is used as the primary planning stress test, not as a prediction.

There is an important tension here that public health planners must confront honestly. Raising public awareness of a potential threat, and encouraging populations to engage with that threat cognitively, is a standard element of public health preparedness - earthquake drills, pandemic planning communications and nuclear emergency protocols all rest on this principle. But this approach implicitly assumes that the population can do something in response: evacuate, shelter, vaccinate or modify behavior. Should the threat come from a technologically superior intelligence, the scope for individual protective action may be limited. Psychological research on uncontrollable threats identifies this as a distinct and difficult category: when individuals perceive a threat but believe they have no effective means of influencing or avoiding it, anxiety responses increase while adaptive coping is undermined – a pattern well established in the stress and helplessness literature. [14,48]

The preparedness framework in this report is designed to be applicable across the full range of possible disclosure scenarios, from relatively benign to genuinely alarming. What this report argues is that preparedness planning cannot be built on the assumption of a favorable disclosure. Preparedness requires honest engagement with the full range of what might be disclosed. Just as planning for pandemics and earthquakes must consider bleaker scenarios, so must planning for disclosure.

4. The Health Needs Assessment

Section 4 sets out uNHIdden's Health Needs Assessment that underpins the preparedness framework in this report. The full HNA is available on the uNHIdden website (unhidden.org), and the methodology, analysis and conclusions are examined in detail in Priestland, De la Torre and Lomas (2026) [17], available as a preprint. What follows is a summary, structured around five key steps.

4.1 Step 1: Define the circumstances in which the health need may arise

A HNA needs to begin by clarifying the set of circumstances against which it is defining the need. Disclosure is not a single event but a spectrum of possible revelations, each with distinct psychological and societal implications. Our HNA therefore developed three primary scenarios.

- **Scenario 1: Distant Biosignature ('Life exists').** Detection of biological or chemical markers in exoplanet atmospheres indicating the existence of life elsewhere in the universe but with no evidence that it is particularly technological or advanced (e.g. simple microbes). This represents the scientifically most proximate scenario given current progress from the James Webb Space Telescope: possible biosignature candidates have been reported in peer-reviewed literature, including contested signals in the atmosphere of exoplanet K2-18b, though these results remain subject to active scientific debate. [49] Psychological impact would be significant but relatively contained: it would require revision of assumptions about humanity's uniqueness without implying any direct threat or immediate practical consequence.

- **Scenario 2: Intelligent Distant Signal ('They're out there').** Reception of clearly artificial signals from an extraterrestrial civilization. This would confirm not merely the existence of life but of non-human intelligence, requiring a more profound revision of humanity's self-understanding. The distance implied by signal propagation would limit immediate safety concerns, but the ontological implications would be substantial.

- **Scenario 3: Local Non-Human Intelligence ('Closer to home').** Confirmation of intelligent non-human presence on or near Earth. This is the scenario with the greatest potential for acute psychological disruption across demographic groups. It implies not just the existence of NHI, but its proximity and agency - and, depending on the circumstances of disclosure, may simultaneously involve revelations about prior governmental knowledge and possible deception, compounding the trust crisis examined in Section 3.2.

The preparedness framework in the HNA was designed principally around Scenario 3, as the scenario most likely to generate demand that could exceed existing mental health infrastructure. Our aim was not to produce a definitive quantitative estimate of the proportion of the population likely to be adversely affected - that would be both methodologically impossible and of limited practical utility. Rather, we sought to assess whether there is a plausible set of circumstances under which disclosure could lead to a public health emergency - formally defined as an extraordinary event posing public health risk requiring immediate coordinated action beyond routine service capacity (WHO [21]; Cabinet Office [25]).

4.2 Step 2: Identify vulnerable populations

Our HNA applies established methodology to identify which population groups face elevated risk from high-impact disclosure. The assessment evaluates potential impact across the two dimensions identified in Section 3.1 - ontological and safety - using a nine-point scale for each, with elevated-risk status defined as a score of 7/9 or above on either dimension. Seven population personas were developed, representing distinct vulnerability profiles based on psychological vulnerability research and demographic analysis.

Impact scores were assigned through a structured expert elicitation process informed by Delphi principles (a structured iterative expert consensus method), but it should be noted clearly that this process does not constitute a full Delphi study in the standard methodological sense. [17, 50] Two authors with complementary subject-matter expertise independently drafted initial scores grounded in established psychological literature on trauma, meaning-making and stress responses. Scores were then refined through iterative structured discussion until consensus was reached. The resulting scores were subsequently reviewed by an external academic with public health expertise and then by a further subject matter reviewer. The rating process considered (i) degree of worldview disruption (ontological dimension); (ii) threat to physical safety and daily functioning (safety dimension); and (iii) availability of psychological resources and social support within each demographic group. Full methodological detail is provided in the companion HNA and companion academic paper. [17]

Persona	Population Characteristic	Rationale for Inclusion
Children	Developmental stage	Represents children's cognitive and emotional development considerations
Young Adults	Identity formation stage	Represents late adolescence and identity formation periods
Parents	Family responsibility	Represents adults managing family and caregiving stressors
Religious Communities	Deeply held religious worldview	Represents populations for whom disclosure challenges theological meaning frameworks
Scientists	Professional scientific identity	Represents individuals whose professional worldview is tied to existing scientific paradigms
Vulnerable Populations	Pre-existing mental health or socioeconomic vulnerability	Represents individuals with reduced psychological resilience or limited coping resources
Experiencers	Prior anomalous experiences	Represents individuals reporting previous UAP or anomalous encounters

Table 1: Population groups represented in the Health Needs Assessment

Population Group	Ontological Impact	Safety Impact	High-Risk Status
Religious Communities	8/9	5/9	High-risk (ontological)
Experiencers	8/9	6/9	High-risk (ontological)
Scientists	8/9	5/9	High-risk (ontological)
Vulnerable Populations	7/9	7/9	High-risk (both)
Parents	6/9	6/9	Lower-risk
Young Adults	6/9	5/9	Lower-risk
Children	4/9	4/9	Lower-risk

Table 2: Ontological and safety impact scores by population group under Scenario 3 (i.e., confirmed NHI presence)

Under Scenario 3, four identifiable demographic groups in the UK population were assessed as at a higher risk. The UK was used as the primary case study throughout this analysis because of data availability. The demographic categories identified are likely to have relevance in other national contexts, including the United States, though direct transposition of prevalence rates would require adaptation to local population data and contextual differences.

Children and young adults - though often assumed by public health planners to be among the most vulnerable - were not classified as elevated-risk under this framework. This reflects the specific character of ontological risk rather than any underestimation of developmental vulnerability. The HNA scoring weighted worldview disruption and threat to professional or personal identity - dimensions on which children and young adults scored lower than groups with more invested meaning frameworks or more fragile coping resources. This is better understood as a conservatism in the methodology rather than a confident prediction: the scoring reflects the specific dimensions assessed, and the true proportion of children and young adults requiring support following high-impact disclosure could well be higher than the framework suggests.

Individuals self-identifying as very religious (approximately 3% of UK adults; approximately 1.7 million people) were assessed as facing the highest ontological impact (8/9). Disclosure of non-human intelligence raises direct challenges to theological frameworks - questions of creation, divine purpose and humanity's special status that many religious traditions have not been asked to confront in this form. This does not imply that religious belief is incompatible with disclosure; theological responses vary considerably and many religious traditions have the resources to accommodate such revelations. Indeed, the profile of vulnerability is likely to vary significantly across traditions, but the initial adjustment period may be severe for those in more literalist or doctrinally committed communities. Targeted interventions for this group are described in Section 7.3.

People with pre-existing mental health conditions or socioeconomic vulnerability (approximately 20% of UK adults; approximately 10.8 million people) were assessed as high-risk on both dimensions (7/9 ontological, 7/9 safety). Reduced psychological resilience and limited coping resources mean that an additional major stressor of this magnitude is likely to compound existing vulnerability. This is the largest high-risk group by population size and the one with the most direct implications for healthcare system surge capacity, as discussed in Section 8.2.

Scientists and STEM professionals (approximately 8.5% of the UK workforce; approximately 2.8 million people) were assessed as a hypothesized elevated-risk subgroup, warranting inclusion as a planning category while recognizing that the evidence base here is less robust than for the other three groups. The assessment rests on Kuhn's analysis of paradigm shifts: when an established scientific framework is superseded, the transition is rarely smooth for those whose professional identity and careers are built within it. [51] Applied to disclosure, scientists may face a more acute form of the ontological disruption experienced more broadly - one in which professional as well as personal meaning frameworks are challenged simultaneously. The evidence base for this classification remains indirect and analogical; it should be treated as a hypothesis for testing rather than a planning certainty. Targeted interventions for this group are described in Section 7.3.

UAP experiencers were assessed at 8/9 on the ontological dimension. A YouGov survey finding that 7% of UK adults report having seen a UFO [52] provides a population planning figure (approximately 3.8 million UK adults). This figure is used as a conservative proxy for planning purposes only: self-reported UFO sightings in a survey context encompass a broader and more varied range of experiences than those described in the clinical and phenomenological literature on anomalous encounters. For this group, disclosure creates a complex dynamic: validation of their experiences may be accompanied by renewed trauma, stigma and the unsettling realization of what those experiences implied. The pre-disclosure work recommended for this group is examined in Section 7.3.

4.3 Step 3: Quantify the number of individuals in high-risk demographic groups

Four groups were assessed as being at elevated risk under Scenario 3: three with an established evidence base (individuals with severe mental health conditions, religious communities, and UAP experiencers) and one hypothesized subgroup requiring further empirical validation (STEM professionals). Together these groups encompass approximately 19.1 million UK adults, around 35% of the adult population. The four demographic categories are not mutually exclusive – an individual with severe mental health conditions may also be very religious, for example – and the true number of unique adults in elevated-risk categories is therefore lower than the aggregate figure. The preparedness case does not depend on a precise adjusted figure; even allowing for substantial overlap, the scale remains sufficient to meet the threshold for a potential public health emergency.

Demographic Group	UK Population	Prevalence	Data Source
Very Religious	1.7 million	3% of adults	YouGov 2014
Vulnerable Populations (pre-existing mental health conditions or socioeconomic vulnerability)	10.8 million	20.2% of adults	NHS England 2023-24
STEM Professionals*	2.8 million	8.5% of workforce	Office for National Statistics 2022
UAP Experiencers	3.8 million	7% of adults	YouGov 2021
Net High-Risk Population*	19.1 million (adult population)	35% of adult population	This study

Table 3: Estimated UK population size of high-risk demographic groups

* STEM Professionals are classified as an elevated-risk subgroup on a hypothesized rather than empirically established basis; see Section 4.2 for full discussion. The four constituent rows use adult population as denominator, while STEM Professionals specifically uses workforce as denominator. Prevalence can be applied to other national adult populations to estimate high-risk groups for other countries, with appropriate adjustment for cultural variations in religiosity, mental health service utilization and STEM workforce composition.

4.4 Step 4: Estimate the proportion of the high-risk population who will be affected

To translate these figures into potential support requirements, the companion HNA applied a planning range of 10-30% of the elevated-risk population experiencing adverse psychological effects requiring some form of support. This range is drawn from Rostami Zarinabadi et al.'s 2025 meta-analysis [53], consistent with the broader disaster mental health literature [54], and involves a significant analogical step: that meta-analysis covers physical disasters, not ontological disruption and there is no direct empirical evidence base for this specific context. The range is not a prediction and individual responses would vary enormously – a significant proportion of the population may demonstrate considerable resilience. What the range is designed to establish is whether there is a plausible pathway to system-level disruption: whether, under reasonable assumptions, demand could exceed existing mental health infrastructure by a margin that warrants preparedness planning. The answer to that question is yes, and that is the basis on which the precautionary principle applies. More robust empirical grounding – the priority for the research agenda in Section 7.2 – will allow future iterations to replace this range with evidence specific to the disclosure context.

The same methodology can be applied to other national populations using the prevalence rates in Table 3, with adjustment for national cultural and demographic differences; the UK figures are therefore presented as a planning sample rather than a UK-specific finding. Applied to the elevated-risk population of 19.1 million - approximately 35% of UK adults - this planning range produces a stress-test figure of 1.9-5.7 million UK adults (3.5-10.6% of the adult population) who might benefit from some form of psychosocial or psychological support following high-impact disclosure. This is a stress-test figure, not a demand forecast - chosen to explore where system limits might lie rather than to predict the most likely outcome. For context, even at the lower bound of the planning range, the additional demand would be equivalent to 37% of annual National Health Service (NHS) mental health referrals in England; at the upper bound, 110%. [55] Given that mental health services are already operating under significant strain - with rising demand, long waiting lists, and workforce pressures - either figure could plausibly exceed system capacity.

A comparable analysis for the United States would be substantially larger in absolute terms, given the population of 267 million adults. We do not extrapolate from UK proportions to U.S. figures, as cultural, demographic, and institutional differences make direct extrapolation methodologically inappropriate. U.S.-specific analysis is a priority for future research. Nevertheless, it seems reasonable to assume that equivalent pressures could arise in the United States following high-impact disclosure - and given that any disclosure is most likely to occur initially there, the absence of preparedness planning in the U.S. context is at least as significant a gap as the one identified here.

4.5 Step 5: Consider whether the circumstances constitute a public health emergency

Our Health Needs Assessment concludes that high-impact disclosure scenarios - specifically Scenario 3 - could plausibly approach or meet the definition of a public health emergency. Based on its planning estimates, the scale of potential demand could represent a surge well beyond routine healthcare capacity. The concentration of that demand within weeks or months of a disclosure event would compound the surge substantially. The cross-cutting nature of the impact - affecting individuals regardless of geography, age or existing health status - would limit the effectiveness of localized responses alone. Further, the simultaneous disruption to the institutional infrastructure that would normally coordinate the response - including healthcare workers, public health officials and policymakers who would themselves be processing the same disclosure – creates conditions qualitatively distinct from previous public health emergencies.

The limits of this assessment should be stated clearly. The expert elicitation process relies on structured expert judgment rather than measured outcomes. Cultural variation in responses may be substantial and is not fully captured in the present analysis. However, none of these limitations undermine the core argument: the precautionary principle holds that planning for plausible high-impact scenarios is justified even when precise probability and magnitude cannot be determined.

To our knowledge, no government has incorporated disclosure preparedness into its national risk assessment framework. The long-established Search for Extraterrestrial Intelligence (SETI) has developed post-detection protocols through the International Academy of Astronautics, addressing verification standards, communication pathways and governance. [56] This is serious and considered work. But the protocols have a structural gap that this report aims to begin addressing: their focus is the management of information (i.e. how a detection is verified, announced and communicated). They say nothing about managing the impact on populations once that information is released. The protocols end, in effect, at the point where the public health challenge begins.

Documents released under the Freedom of Information Act, originating from at least as early as 2020, confirm that NASA personnel were developing an internal communications protocol for a confirmed discovery of extraterrestrial life. [57] Those materials explicitly recognize that a discovery would be received unevenly across society and that NASA's role would extend beyond information provision to facilitating interpretation, dialogue and "meaning-making" across diverse communities – including providing resources for contextualisation, supporting public discourse and helping shape population-level responses. However, while this reflects a clear recognition of the psychosocial dimension of disclosure, it does not constitute a comprehensive preparedness framework for managing population-level impacts once such information is released.

Having established both the need and its scale, the next step is to develop the interventions that can help manage and mitigate the consequences of high-impact disclosure scenarios. The conceptual bridge between identified need and intervention design is the Theory of Change, set out in Section 5.

5. Theory of Change

5.1 What is a Theory of Change and how is it used?

A Theory of Change is a methodology for planning, participation and evaluation used in complex social interventions. It was developed by Carol Weiss and colleagues at the Aspen Institute as a way of making explicit the causal logic assumed - often implicitly - in any social program: the chain of conditions and mechanisms that links activities to their intended outcomes. [58] ToC has since become a standard tool in international development, public health program design and policy evaluation. It is particularly well suited to interventions characterized by complexity, novelty and scale - all three of which apply to high-impact disclosure scenarios.

5.2 The uNHIdden Theory of Change

The uNHIdden ToC set out on the next page maps the pathway from root causes through resources and activities to implementation outcomes, mechanisms of change and end outcomes. The framework is designed to operate across a range of plausible disclosure scenarios - gradual, abrupt and ambiguous - rather than assuming a single discrete event. This is not merely a modeling assumption. Gradual or partial disclosure - incremental official acknowledgment, leaked materials or accumulating public evidence - is at least as likely as a single defining announcement. The preparedness infrastructure must therefore be designed to function under conditions of ambiguity and uncertainty, not only in response to a clear triggering event. Much of the pre-disclosure work - building conversation infrastructure, validating experiencer testimony and developing trusted voices - generates public readiness that is independent of any formal governmental announcement and valuable regardless of how disclosure unfolds.

The ToC diagram presents pre-disclosure and post-disclosure phases for each activity category. The post-disclosure phases are shown in simplified form, because the primary purpose of this report is pre-disclosure preparedness (i.e. building the capacity that will determine how effective any post-disclosure response can be).

The root causes are twofold. At the individual level, there are psychological consequences of responses to paradigm-shifting information - the anxiety, disorientation and disruption to meaning-making examined in Section 3.1. At the societal level, there is the absence of preparedness infrastructure, misinformation dynamics (of the kind documented by the MIT Media Lab study discussed in Section 3.3) [47] and the epistemic instability produced by decades of inconsistent official communication (the trust implications of which are set out in Section 3.2).

Theory of Change: Disclosure Preparedness and Response

The Theory of Change below maps the pathway from root causes through to end outcomes, across both pre- and post-disclosure phases. It provides the conceptual framework for the interventions described in Sections 6, 7 and 8.

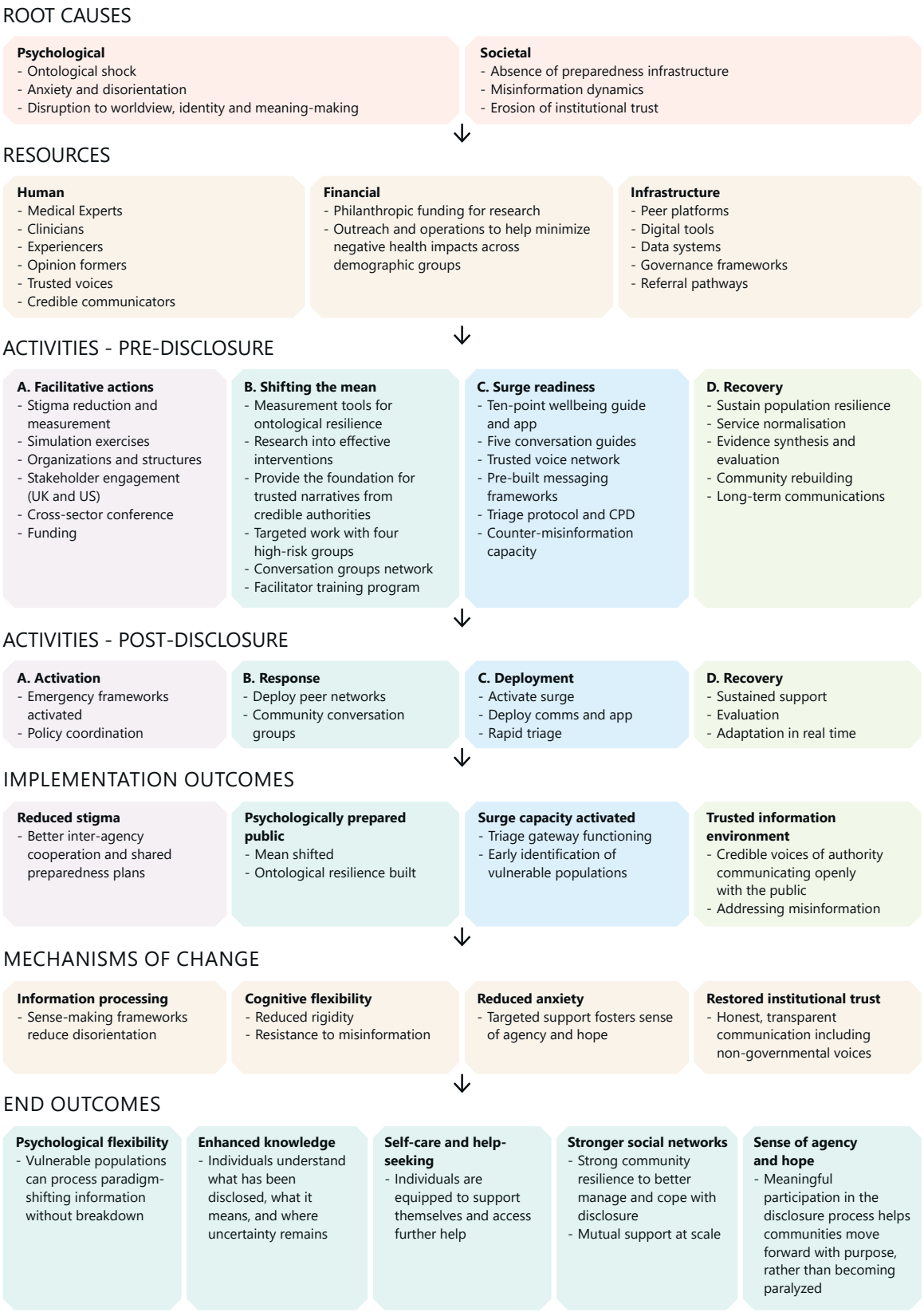

Figure 1: Theory of Change - Disclosure Preparedness and Response

The ToC organizes preparedness activities across four categories.

- Category A covers facilitative actions: stigma reduction, simulation exercises, cross-sector organizational development and stakeholder engagement. Category A encompasses the system-level conditions without which other preparedness activities cannot succeed.
- Category B covers shifting the mean: building population resilience in response to paradigm-shifting information (corresponding to Geoffrey Rose's first public health function described in Section 1.2 [8]) through research, targeted group work and the conversations infrastructure.
- Category C covers surge readiness: the capacity built up pre-disclosure and activated at the point of disclosure, incorporating self-help tools, practitioner preparedness training, communications frameworks and the triage function that routes individuals from community support into clinical care where needed.
- Category D covers recovery: sustaining population resilience and restoring social and institutional function over the medium to long term.

Each ToC category has a pre-disclosure phase, in which capacity and infrastructure are built up, and a post-disclosure phase, in which those preparations are activated. Categories A, B and C correspond to Sections 6, 7 and 8 respectively. Category D is addressed in Section 8.5.

The four ToC categories produce four implementation outcomes:

1. reduced stigma and inter-agency cooperation;
2. a better-prepared public;
3. activated surge capacity with triage functioning; and
4. a trusted information environment.

These positive effects result from mechanisms of improved information processing, cognitive flexibility, reduced anxiety and restored institutional trust. This, in turn, leads to psychological flexibility, enhanced knowledge, self-care capability, stronger social networks and a sense of agency and hope.

A ToC is only as robust as its assumptions. This model relies on the following key dependencies:

1. that credible non-governmental intermediaries can be identified and prepared in advance;
2. that high-risk communities will engage with pre-disclosure outreach;
3. that delivery channels – including digital tools, community networks and trusted intermediaries – will effectively reach those who need support;
4. that referral pathways can integrate with existing clinical services; and
5. that post-disclosure governmental communications will be sufficiently transparent and consistent to support rather than contradict community-level support efforts.

These assumptions do not invalidate the model, but they define critical dependencies whose validity will need to be tested and adjusted through implementation.

5.3 Framing and communicative tone

One observation from the historical literature is worth carrying into communications design. The assumption that humanity is alone in the universe is, in historical terms, unusual. Across cultures and centuries, most human cosmologies have taken it for granted that the universe is populated with intelligences beyond the human - whether divine, spiritual or otherwise. The modern assumption of aloneness is the exception, not the rule. This is offered not as an argument but as a framing resource - one that allows disclosure to be positioned as an expansion of human understanding rather than a rupture with it, as discussed in Section 5.3.

A critical risk in disclosure preparedness communications is iatrogenic framing: the possibility that the preparedness message itself generates the distress it is designed to mitigate. Leading with questions such as 'are you coping?' or 'do you need support?' signals that distress is the expected response. This risk is compounded by the tension identified in Section 3.4 between honest communication about potential threat and the psychological cost of awareness without agency.

Honest acknowledgment of uncertainty and potential threat is not incompatible with this framing. The goal is not to minimize what may be difficult, but to ensure that awareness leads to agency rather than paralysis.

The preferred alternative is a framing of curiosity and meaning-making - positioning disclosure as an expansion of human understanding rather than an assault upon it. All four ToC categories should be framed around human flourishing, not pathology management. This framing principle is discussed throughout Sections 6, 7 and 8.

6. Facilitative Actions

6.1 Context and approach

Primary responsibility for population health and wellbeing rests with governments. In an ideal world, the framework set out in this report would be developed and owned by government health departments, public health agencies and professional bodies working in partnership. The reality, however, is that the UAP topic carries significant institutional stigma. For many governments, open engagement with disclosure preparedness - however rational as a precautionary measure - would be politically difficult.

It may therefore fall to civil society organizations to take the initiative in the near term: convening, demonstrating proof of concept, building the evidence base and creating the conditions under which institutional engagement becomes safer and more natural - explicitly in order to bring governments and professional bodies to the table, not to substitute for them. This is a recognition of what civil society can realistically do now - and of what becomes possible as the political environment around disclosure continues to evolve. This report is designed with that in mind: moving forward where civil society can act, and working toward a next iteration developed with governments and all relevant stakeholders at the table.

uNHIdden's role is that of initiator and convenor, not lead deliverer. This report represents a credible first version of a plan - one that invites challenge, scrutiny and most of all engagement. The aim is to start to build a coalition for meaningful action. Section 9 sets out a possible action program covering what a multi-agency response would need to look like, and identifies the organizations with both the capacity and the authority to lead the various workstreams.

Three categories of intervention are required for disclosure preparedness to become a serious field of public health practice: facilitative work that creates the conditions for everything else; resilience-building that equips individuals and communities to cope with disclosure; and surge readiness that ensures clinical and support systems can respond at scale when needed. The first of these, addressed in this section, is the necessary precondition for the other two: without reducing stigma, convening the right organizations and securing the engagement of governments and professional bodies, the resilience-building and surge-readiness work described in Sections 7 and 8 cannot reach the populations that need it.

6.2 Reducing stigma

Stigma around serious engagement with anomalous experiences and paradigm-shifting information is the primary obstacle to disclosure preparedness. It suppresses experiencer testimony, discourages clinical engagement, constrains journalistic and academic coverage and makes institutional action politically difficult. Reducing it is therefore the necessary first step for almost everything else described in this report, including the targeted group work for high-risk populations described in Section 7.3 and the clinical recognition sought through Section 7.6.

Stigma reduction at population scale does not happen through the production and distribution of information materials alone. The evidence from comparable campaigns points to a different mechanism: social contact interventions, in which people hear directly from those with lived experience, consistently produce larger short-term improvements in stigma-related attitudes than education-only approaches, although the durability of those effects remains an area of active research. [59] The Time to Change program in England - an anti-stigma initiative delivered by Mind and Rethink Mental Illness between 2007 and 2021 - incorporated both mass social marketing and structured contact events and, over its fourteen years of delivery, produced significant population-level improvements in mental-health-related stigma. This was in terms of public knowledge, attitudes toward people with mental illness and people's willingness to maintain social contact. [60] However, follow-up data suggest that those gains were not sustained after the program ended in 2021, with stigma-related knowledge and desire for social distance returning to 2009 levels by 2023. This underscores that stigma reduction requires ongoing investment rather than time-limited intervention - a lesson directly applicable to any UAP-related stigma reduction program.

Three mechanisms for stigma reduction are indicated by these public health efforts.

The first is mainstream media and public discourse. The topic needs to be treated seriously - neither sensationally nor dismissively - by science journalists, broadcasters, documentary makers and public intellectuals. This is already beginning to happen, but unevenly: serious journalism, congressional hearing coverage and a small number of academic publications have begun to shift the register in which UAP-related questions are discussed. What is needed is sustained, intentional engagement - the provision of credible briefing materials, access to authoritative voices and the cultivation of relationships with editors and producers who can champion serious coverage of the issue over time.

The second mechanism is institutional permission-giving. When learned societies, professional bodies and academic institutions signal that it is legitimate to engage with paradigm-shifting questions - and that doing so does not carry career risk or reputational damage - individual scientists, clinicians and academics who might otherwise self-censor become willing to participate. Position statements, commissioned research and conference programs are the instruments through which this permission is given. Engagement with the UK Royal Society, the Royal Academy of Engineering, the British Academy, and their U.S. equivalents is therefore a stigma-reduction action as well as a structural one. This institutional permission-giving is of particular relevance to the STEM professional population identified as high-risk in Section 4.2. Faith communities matter here too. Where trusted religious institutions engage seriously with the possibility of non-human intelligence, they extend permission to populations that may be less responsive to scientific or governmental voices.

The third mechanism is community-level contact through conversation groups. The uNHIdden Conversations Group, currently in pilot in Australia, provides the model: a structured, facilitated group in which people can discuss anomalous experiences and disclosure-related questions safely, seriously and without ridicule. The groups are not therapeutic interventions and do not provide medical advice or treatment; they are facilitated peer conversations.

The pilot has focused primarily on experiencers, but the model is designed to be expandable to the general population. A network of such groups operating across multiple geographies and community settings would provide both the social contact mechanism that stigma reduction requires and the community infrastructure that surge readiness demands, as described in Section 8.2. What is needed is not for uNHIdden to run these groups - that is not scalable - but for the model, training framework and safeguarding protocols to be sufficiently developed that community organizations and other third-party organizations can adopt and replicate them.

Baseline measurement of stigma levels - across the general population and within each high-risk group identified in Section 4.2 - should precede and accompany all stigma-reduction work, so that progress can be tracked and interventions improved as evidence develops. However, validated instruments for measuring UAP-related stigma do not currently exist. Adapting existing mental-health stigma measures or developing new ones appropriate to this context is itself a priority research task, and one that should be initiated early in any preparedness program, before stigma-reduction interventions begin.

6.3 Simulation

A structured simulation exercise - modeled on the design principles of Exercise Cygnus (the UK's 2016 pandemic preparedness exercise) and Crimson Contagion (the 2019 U.S. equivalent), both discussed in Section 2.1 - is one of the highest-leverage actions available for emergency preparedness. Exercises of this kind have a well-established function: they create a legitimate, structured occasion for emergency planners, health commissioners, clinical leads and third-party organizations to work through a scenario together, identify gaps in existing planning and build the relationships and shared understanding that effective response requires. Critically, participation does not require any participant to make public commitments about the scenario being exercised. Governments and institutions can participate without endorsing any particular view of the probability of disclosure. The exercise could be run privately and discreetly, which would lower the barrier to participation significantly.

The exercise should be designed around a range of plausible scenarios - gradual, abrupt and ambiguous - rather than a single anticipated event, and should test the response of existing public health and emergency management frameworks against the specific characteristics of a psychological and ontological emergency. The output - a formal after-action report identifying gaps in existing planning - would provide the evidential foundation for subsequent engagement with UK agencies including NHS England and the UK Health Security Agency, and U.S. agencies including SAMHSA, and for the case that disclosure preparedness warrants inclusion in the national risk register in the UK and the THIRA process in the United States, as discussed in Section 2.4.

Exercises of this kind require specialist emergency planning expertise and significant resourcing. They are typically initiated by government bodies or major academic public health institutions.

What is needed is for an organization with appropriate standing to take the lead on design and facilitation, with the scenario content and analytical framework provided by those who have developed the preparedness case. In practice, such an exercise is most likely to proceed under a broad resilience or extreme risk framing, rather than as a standalone disclosure-specific exercise, to align with existing institutional mandates and lower the threshold for participation.

6.4 Building the coalition

As set out in Section 6.1, governments may currently be constrained in their ability to engage openly with disclosure-related planning, and formal health systems have no existing frameworks for this challenge. A central facilitative action is therefore the convening of a cross-sector network willing to work on this problem outside - and ahead of - formal governmental structures. The purpose is to build the evidence base, develop the frameworks and demonstrate proof of concept, so that government health departments and public health agencies have something concrete to adopt and build on when they are ready to engage.

It should be noted that in many disclosure scenarios, the initial response architecture is likely to be led by defense and intelligence structures - including the Office of the Director of National Intelligence, the Department of Defense and interagency coordination mechanisms such as the National Security Council - rather than health agencies, with allied partners including Five Eyes (the intelligence alliance comprising the US, UK, Canada, Australia and New Zealand), NATO and, in the UK the Cabinet Office, engaged in parallel. The coalition-building described here is necessarily dependent on that broader landscape, which this report does not address.

uNHIdden is proposing to convene a cross-sector conference to bring together institutional, academic and community stakeholders to stress-test the analysis and proposed actions in this report, identify which organizations are willing to lead specific workstreams and begin building the coalition without which a program of this scope cannot be delivered. Given that any disclosure is most likely to originate in the United States, the preference is to hold the conference there, or to convene linked events across multiple countries.

Beyond the conference, sustained cross-sector convening requires engagement with bodies that occupy the productive middle ground between government and the private sector: in the United States, the National Academy of Sciences, the American Academy of Arts and Sciences and Associated Universities Incorporated; and in the United Kingdom, the Wellcome Trust, the Royal Society and the British Academy. Academic institutions in both countries could host and support this work, alongside nonprofit organizations with established expertise in mental health, community resilience and science communication.

The engagement with governments and professional bodies has two distinct but related purposes. The first purpose is recognition: persuading government health departments, public health agencies and professional bodies that disclosure preparedness is a legitimate planning challenge that warrants their attention.

In the U.S., the relevant bodies are the Department of Health and Human Services, the Centers for Disease Control and Prevention, FEMA and SAMHSA. In the UK, the equivalent bodies are the Department of Health and Social Care, the UK Health Security Agency and the Cabinet Office Resilience Directorate. The clinical bodies whose engagement is essential are the American Psychiatric Association and the American Psychological Association in the U.S., and the Royal College of Psychiatrists and the British Psychological Society in the UK. The British Association for Counseling and Psychotherapy and the Royal College of General Practitioners are equally important in the UK context, given their role in the CPD architecture described in Section 8.2.

Participating organizations are not being asked to endorse any particular view of the probability or nature of disclosure. The request is more limited: that they acknowledge that if high-impact disclosure occurs, there will be a public health consequence that existing frameworks are currently unprepared for, and that beginning to address that gap now is the rational precautionary response.

The second purpose is structural: building, in advance of any possible disclosure, the relationships, shared understanding and institutional credibility that an effective response would require. The COVID-19 response illustrated - for better and worse - that trusted scientific advice at population scale depends on institutional structures built before they are needed. A disclosure scenario would require something analogous: an identifiable, interdisciplinary advisory body - a Disclosure Preparedness Advisory Group - capable of providing credible, independent guidance across the range of questions that disclosure would raise, from the psychological and public health dimensions to the theological and philosophical ones. The group would need to draw on a wider range of expertise than conventional public health advisory bodies - including philosophers, theologians and representatives of faith communities, alongside clinicians, social scientists and emergency planners. uNHIdden's OSAG, in its current form, represents one contribution to that network-building - and the proposed conference is an opportunity to begin constituting it more broadly.

7. Shifting the Mean: Building Ontological Resilience

7.1 Objective and scope

Ontological resilience, as used in this report, refers to the capacity of individuals and communities to process disruptive or paradigm-shifting information without severe psychological dysfunction - and to do so in ways that support meaning-making and adaptive responses rather than denial, panic or withdrawal. The objective is to shift that capacity upward across the population - so that if high-impact disclosure occurs, more people are better placed to process and adapt to what emerges, and fewer are overwhelmed by it.

As set out in Section 1.2, Geoffrey Rose's foundational argument in preventive medicine is that population-wide interventions which produce small reductions in average risk across the whole population often generate greater aggregate benefit than concentrating resources exclusively on those most severely affected. [9] Applied here, the goal is not primarily to provide intensive support to those who will be most severely affected by disclosure (which is the purpose of the surge readiness work in Section 8), but rather to reduce the number of people who will need intensive support in the first place. A population progressively familiarized with the possibility of paradigm-shifting revelations, and equipped with frameworks for thinking about them, is less likely to be overwhelmed when that possibility arrives.

7.2 The research imperative

The necessary starting point is an acknowledgement of uncertainty. We do not currently know with confidence what builds resilience to paradigm-shifting information at population scale. There is no body of research that directly addresses this question, and the analogous literature (on responses to other kinds of paradigm-shifting discovery, including post-traumatic growth and ontological shock in individual clinical contexts) provides useful but incomplete guidance. Commissioning rigorous empirical inquiry into the psychological and social mechanisms that support or undermine ontological resilience is the foundational action in this area. Research is the necessary first step before investing heavily in interventions whose effectiveness is unproven.

Alongside the research program proposed in this report, exploratory measurement approaches for responses to paradigm-shifting information need to be developed: instruments capable of assessing the degree of ontological shock experienced by individuals and the factors (individual, social, cultural and institutional) that moderate or amplify it. Developing such instruments requires collaboration among clinical psychologists, public health researchers and the qualitative researchers who have worked most closely with UAP experiencer communities. The aim is not to establish a new clinical category, but to generate the measurement capacity necessary to assess the effectiveness of any preparedness intervention.

7.3 Targeted work with high-risk groups

While the research program develops, four categories of targeted intervention are indicated by the Health Needs Assessment in Section 4, corresponding to the four groups that are identified as facing elevated risk. These are not the only population groups that may require support - for example, the HNA also identified parents and children as warranting attention and other groups may emerge as the evidence base develops. However, the four high-risk groups represent the current best assessment of where targeted intervention is most urgent; strategies for additional groups will be developed as priorities are refined and resources allow. The interventions described here reflect the available evidence and expert judgment; they should be treated as hypotheses to be tested rather than established protocols.

For religious communities, the challenge of disclosure is not simply one of communication. For some – particularly those in traditions with more defined cosmological frameworks – confirmation of NHI would raise genuine theological questions about creation, humanity's assumed unique status and the nature of sacred narratives. Different traditions will draw on different resources for engaging with these questions; the task for preparedness is not to provide theological answers, but to ensure that space exists for those conversations to happen with support from people with appropriate pastoral training and standing. The specific actions indicated are:

1. resources to be developed in genuine partnership with interfaith organizations, rather than imposed from outside; and
2. the preparation of faith leaders and pastoral workers to hold disclosure-related conversations in congregational settings in advance of any significant disclosure development.

For STEM professionals, the challenge relates to professional identity and established paradigms, as discussed in Sections 3.1 and 4.2. Two actions are necessary to meet the challenge. The first is engagement with learned societies to develop position statements that provide scientists and engineers with institutional legitimacy to engage with paradigm-shifting questions without career risk - addressing the structural barrier before it becomes an individual one. The second is support for relevant research through mainstream academic publication pathways, particularly on the psychological and societal dimensions of paradigm-shifting disclosure, so that serious academic engagement with the topic becomes professionally normalized rather than reputationally risky. Both depend on the stigma-reduction work in Section 6.2 having made sufficient progress to make participation safe.

For vulnerable populations - those with pre-existing mental health conditions or facing socioeconomic disadvantage, insecure housing - the priority is to ensure that support infrastructure reaches those least likely to seek help unaided. As set out in Section 1.2, proportionate universalism - the principle that interventions should be universal but delivered with a scale and intensity proportionate to the level of disadvantage, as developed by the epidemiologist Michael Marmot [61] - is the guiding principle. Vulnerable populations as a whole constitute the largest high-risk cohort identified in Section 4.2 and represent the greatest single pressure point on NHS surge capacity as described in Section 8.2.

For UAP/NHI experiencers - individuals who have had anomalous encounters and may have been carrying the burden of those experiences in conditions of stigma and disbelief - the pre-disclosure work has one primary objective and one likely consequence. The primary objective is care and validation: creating safe, stigma-free spaces in which individuals can share what they have encountered, have it taken seriously, and process its implications without fear of ridicule or dismissal. The likely consequence - in which UAP/NHI experiencers feel genuinely heard and choose to share their experiences more widely - is that testimony shared openly, and taken seriously on its own terms, will contribute to broader public familiarity with paradigm-shifting possibilities.

7.4 Building a trusted voice network

A network of trusted, high-profile voices (scientists, clinicians, theologians, philosophers and public intellectuals) willing and able to engage publicly and seriously with paradigm-shifting questions is a medium-term goal that depends on the stigma-reduction work in Section 6.2 having made sufficient progress to make that engagement professionally safe. Pre-disclosure, the network contributes to the gradual normalization of serious engagement with the topic. Post-disclosure, it supplies the credible, independent voices on which the communications response will depend – the first and most critical of the four elements of the readiness strategy described in Section 8.3. The network requires explicit selection criteria, diversity requirements across disciplines, demographics and cultural backgrounds, and independence safeguards that protect it from association with any particular position on the nature or interpretation of disclosure

7.5 The conversation groups as a resilience-building instrument

The conversation groups introduced in Section 6.2 serve a dual function. In their facilitative role, they are a mechanism for stigma reduction: providing the social contact through which attitudes shift. In their resilience-building role, addressed here, they are a mechanism for ontological resilience: providing the structured, facilitated space in which individuals can engage cognitively and emotionally with paradigm-shifting possibilities before any disclosure event occurs, developing the frameworks for meaning-making that individuals will draw on when they are needed.

As stigma reduces and the groups mature, their role shifts from providing a safe space to discuss the topic to actively helping participants build the cognitive and emotional frameworks that support ontological resilience. Facilitator training should be designed to reflect both purposes. The conversation groups are, in this sense, one of the most important instruments in the pre-disclosure preparedness program: they reduce stigma, build resilience, provide community infrastructure for surge readiness (as described in Section 8.2), generate qualitative evidence about how people are processing the topic and create the social fabric that would support recovery. Scaling these groups is not a task for uNHIdden alone; they need to become a distributed, community-led resource.

7.6 Clinical recognition

Seeking recognition of ontological shock as a plausible area for further clinical study – in engagement with the American Psychiatric Association, the American Psychological Association, the Royal College of Psychiatrists and the British Psychological Society – is the institutional action that would give the resilience-building work its professional legitimacy. The request is modest and scientifically defensible: not the creation of a new diagnostic category, but the acknowledgment that paradigm-shifting information can cause genuine psychological distress that warrants clinical attention and research. As noted in Section 3.1, ontological shock does not map cleanly onto existing categories such as PTSD or grief. Standard therapeutic interventions may not translate directly to these scenarios, and developing validated approaches requires the kind of clinical research that professional body recognition would enable. This recognition is also a prerequisite for the practitioner CPD program described in Section 8.2, which depends on the professional bodies whose engagement is sought here.

8. Surge Readiness

8.1 Objective and scope

The objective of this section is to ensure that, if high-impact disclosure occurs, the response does not have to be assembled immediately from scratch. Everything described here must be built, tested and ready before it is needed. The real measure of success is not whether the model is well designed on paper but whether, at the very moment of disclosure, each element is genuinely ready to be activated. As noted in Section 3.3, a major revelation would be distributed globally within minutes. The window for shaping the initial public response is extremely narrow and anything that has not been built in advance will not exist in sufficient time to matter.

Surge readiness has two distinct phases. The pre-disclosure phase is about construction: building the tools, networks, protocols and communications architecture that will be needed. The post-disclosure phase is about activation: deploying what has been built, at speed and at scale, in conditions of high demand, information complexity and institutional pressure. Both phases are addressed in this section.

8.2 The surge response model

The surge response is designed to operate through four layers, each absorbing different levels of need and capable of functioning even if higher layers are overwhelmed. The layered architecture reflects the three-layer model of health system resilience described by Zhao and colleagues and discussed in Section 2.2, adapted to the specific characteristics of a psychological and ontological emergency. [28] The COVID-19 experience is directly relevant here: as noted in Section 2.2, mental health demand did not peak in the first weeks of the pandemic, but grew for months and years. The four-layer model is designed to sustain capacity over the medium term, not only at the immediate point of disclosure.

The model operates through four layers: (1) self-help resources; (2) community support through conversation groups; (3) structured therapy and practitioner support; and (4) triage and clinical referral. Each is described below.

Before describing each layer, it is necessary to address the safeguarding risks that community and peer-based support mechanisms carry. Any model that deploys facilitated conversation groups, peer networks and digital tools at scale must explicitly plan for the possibility of harm as well as benefit. The specific risks include:

1. a facilitated group that amplifies rather than contains distress if the facilitator is inadequately trained;
2. a group that falls under the influence of a dominant individual promoting a particular narrative or belief system;
3. misinformation circulating unchallenged within a community that feels safe but lacks clinical oversight;

4. someone in genuine psychiatric crisis not being identified or referred to appropriate services; and
5. personal data collected through digital tools being inadequately protected.

These risks are manageable, as established peer support and community mental health models have developed safeguarding architectures over decades, but they require deliberate design rather than assumption. Safeguarding protocols, clear escalation rules, facilitator supervision and regular monitoring must be integral to the model from the outset, not retrofitted once programs are in operation. The conversations group model (A2 in the implementation table in Section 9.2) – which includes legal and ethical assessment of duty of care to participants, safeguarding protocols and escalation rules - is the primary instrument for ensuring the existence of safeguards.

The first layer is self-help: resources that individuals can access without any professional intermediary. uNHIdden is developing two primary instruments for this purpose. The first is a wellbeing support guide - currently being finalized and subject to sign-off by the uNHIdden Medical Advisory Board - designed to help individuals manage the anxiety and disorientation that disclosure-related information may produce with practical, clinically grounded guidance. The second is a suite of conversation guides - structured tools designed to help facilitators and individuals engage constructively with disclosure-related questions - also currently under development and subject to the same review process. Both instruments need to exist in final, tested form before any disclosure event, ready for immediate mass distribution. The question of how they are distributed at scale is itself a preparedness challenge: at the moment of disclosure, digital distribution will be essential and this may require the development of a dedicated app or platform in advance. Finalizing the resources themselves is the immediate priority; the distribution platform is a subsequent development task.

The second layer is community support: facilitated conversation groups activated rapidly across multiple geographies, providing structured, grounded spaces for people to process what has been disclosed together rather than alone and online. The conversations group model described in Section 7.5 is the ideal instrument – and there is an important continuity here. The same groups that, pre-disclosure, provide a safe space for serious engagement with paradigm-shifting possibilities and help build ontological resilience become, post-disclosure, the primary community support mechanism. They do not need to be created from scratch at the moment of crisis; they need to be sufficiently developed, with trained facilitators and tested safeguarding frameworks, that they can switch rapidly from resilience-building to active support and scale across multiple settings without requiring extensive setup. The conversations group model is currently at pilot stage; the evidence base for its effectiveness at scale is not yet established. Scaling is contingent on positive pilot evaluation, which is a near-term priority. This continuity – the same infrastructure serving both preparedness and response – is one of the most efficient features of the model.

The third layer is structured therapy and support. Therapists, counselors and general practitioners need to have completed relevant continuing professional development before disclosure occurs, not in response to it.

The reactions that disclosure may produce across general populations - overlapping with acute stress, adjustment disorder and existential crisis, but sharing a common trigger in paradigm-shifting information - are not well covered by existing clinical training, and practitioners encountering them without preparation are unlikely to respond effectively. The CPD required need not be extensive: a well-designed module covering the nature of ontological shock, its clinical presentation, appropriate therapeutic responses, escalation thresholds and the specific vulnerabilities of high-risk groups would represent a realistic and proportionate starting point. Framing this module around reactions to paradigm-shifting information more broadly - encompassing disclosure scenarios alongside other civilization-scale revelations, such as the advent of artificial general intelligence - would make it both more professionally acceptable and more durable as an investment. The CPD should be developed in partnership with the American Counseling Association, the American Psychological Association, the American Academy of Family Physicians, the British Association for Counseling and Psychotherapy, the British Psychological Society, and the Royal College of General Practitioners, and delivered through existing CPD systems rather than a parallel practitioner network. The clinical recognition sought through Section 7.6 is the enabling condition for this work.

The fourth layer is triage, assessment and treatment of more significant mental health difficulties. The great majority of people affected by disclosure will not require clinical intervention – they may be distressed, alarmed, disoriented or struggling to process what they have learned, but these are normal human responses to extraordinary news. The self-help resources, conversation groups and practitioner support described in the first three tiers are designed precisely to meet that majority need. What triage addresses is the small minority whose response crosses into clinical mental health territory – acute psychiatric crisis, severe decompensation, or other presentations requiring urgent clinical assessment – and who need to be identified quickly and routed into appropriate care. This includes assessment and referral pathways for those presenting elevated risks of harm to themselves or others, consistent with existing emergency mental health frameworks.

The parallel with UAP/NHI experiencer support is instructive: most individuals who report anomalous encounters are processing something strange and unfamiliar, while a small number are in more significant psychiatric distress and need clinical help. Community hubs and points of access to clinical services, including primary care, should be equipped with knowledge of care pathways that enable triage and access to appropriate onward care and support. A clear protocol – developed and tested with NHS England, integrated care boards, SAMHSA and equivalent partners in advance, and compatible with existing emergency mental health frameworks – is the essential bridge between community-level support and formal healthcare. Without it, the minority who genuinely need clinical services risk being missed amid the much larger number who do not.

Technology may have a role as an amplifier across all four tiers - distributing resources rapidly, hosting conversation groups at scale, and supporting triage signposting - but it supplements human-centered support rather than substituting for it.

Technology development at this scale is beyond the current resources of a small non-profit organization since the data protection obligations, security requirements and ongoing maintenance demands that any meaningful digital platform would carry require resources and infrastructure beyond those of a small non-profit organization. The development of technology-based tools is therefore identified here as a workstream for better-resourced partners - whether NHS digital infrastructure, established mental health platforms, or technology sector organizations with appropriate governance and security capabilities.

8.3 Building communications readiness

A communications strategy that begins at the point of disclosure has already failed. Everything in this section must be built, tested and ready before it is needed. The scale of the challenge is illustrated by what might be called the twenty-minute problem: as the MIT Media Lab analysis discussed in Section 3.3 [47] demonstrates, false information travels faster than true, and the window for shaping the initial public response is extremely narrow.

Two elements of communications readiness require pre-disclosure preparation. The first element is the trusted voice network described in Section 7.4, understood here in its full continuity: these are not voices that switch on at the moment of disclosure, but credible public figures already engaged pre-disclosure in normalizing serious public conversation about paradigm-shifting possibilities. Post-disclosure, that same network of influencers - alongside the more formal advisory body described in Section 6.4 - would become the primary source of credible independent commentary, and the most realistic mechanism for countering misinformation at scale. As noted in Sections 3.2 and 3.3, governments may face both a trust deficit and practical limits on their ability to control information flow; authoritative voices that are independent of government may carry more weight precisely because of that independence. The second element is group-specific messaging frameworks, developed in advance for the demographic groups most likely to need them. These should be aligned with, but not limited to, the high-risk groups identified in the HNA. They should include:

1. resources for parents and schools on how to talk to children about what has been disclosed;
2. material to support STEM professionals engaging with paradigm disruption;
3. guidance developed with religious communities for theological reflection; and
4. support for UAP/NHI experiencers, for whom disclosure may resurface previous encounters, fears or long-standing distress from those experiences being dismissed or ridiculed.

8.4 Immediate response

When disclosure occurs, the surge capacity built in this section activates. The quality of that response is a direct function of the quality of pre-disclosure preparation – where elements are more mature, they deploy more readily; where they are less developed, improvisation will be required and effectiveness will be reduced. The primary instruments at the moment of disclosure are:

1. immediate distribution of the wellbeing guide and conversation guides through whatever channels are available;
2. rapid scaling of conversation groups;
3. deployment of the trusted voice network and the Disclosure Preparedness Advisory Group;
4. activation of the triage pathway; and
5. dissemination of the group-specific messaging frameworks to the communities that need them.

The framing principle established in Section 5.3 matters most in the immediate period after disclosure occurs. The instinct to open with 'are you struggling?' or 'do you need support?' should be resisted in public-facing communications and group facilitation - it signals that distress is the expected response and may create the very anxiety it is trying to address. Clinical triage and assessment operate differently and should follow established mental health frameworks. The better entry point is curiosity and openness: what has been disclosed, what it means, what remains uncertain and where genuine concern is warranted. Honesty about all the facts, including difficult ones, is more stabilizing than reassurance that contradicts what people can see for themselves. The targeted preparations made in Section 7.3 for each of the high-risk demographic groups identified in the HNA are designed precisely for this moment and should be activated as part of the immediate response.

8.5 Recovery

Recovery (i.e. the period from approximately four weeks to two years following the moment of disclosure) is not a return to the pre-disclosure status quo. It is the construction of a new normality in which what has been disclosed is integrated into public understanding, institutional frameworks and individual meaning-making. The transition from surge to sustained support is one of the most operationally difficult moments in any public health emergency. The COVID-19 experience, discussed in Section 2.2, is a direct precedent - mental health demand did not peak in the first weeks of the pandemic, but continued to grow for months and years. The conversation groups must continue operating at scale after the recovery period; the practitioner network must be maintained and its knowledge base kept current with triage pathway remaining operational.

Over the longer term, communications shift from crisis framing - what is happening, what it means, and where to get help - to integration framing: how the disclosed information changes our understanding of ourselves and our world. Counter-misinformation work continues, but the medium-term challenge shifts to building public resilience to misinformation.

Systematic evaluation of which interventions worked, for whom and under what conditions is both a public health obligation and a prerequisite for improving preparedness for any future paradigm-shifting events.

The deepest form of recovery is generational. Just as there are increasing numbers of people who cannot remember a world before the internet, there would come a point when most people cannot remember a world before disclosure - for whom the reality of non-human intelligence is simply part of the given conditions of human life. Planck observed that new scientific truths tend to prevail not by convincing those who resist them, but because a new generation grows up already familiar with them. [62] That may ultimately be true of disclosure too. The task of public health preparedness is not to resolve that long arc - it is to ensure that the transition is navigated with as little unnecessary suffering as possible.

9. Implementation

9.1 A call to action

This report describes the necessary steps for high-impact disclosure of paradigm-shifting information to be met with an adequate public health response. This section sets out the organizations and individuals best placed to take forward the various actions, and the basis on which they are invited to do so.

The disclosure preparedness program cannot be delivered by any single organization. It encompasses stigma reduction, clinical research, simulation exercises, institutional engagement, community infrastructure, practitioner training, communications architecture and structural development over a period of years. uNHIdden's role is that of initiator and convenor - making the case, demonstrating proof of concept in the areas where it can act directly, and creating the conditions for others to engage. What follows directly from uNHIdden are:

1. the wellbeing support guide and conversation guides, once finalized and signed off by the Medical Advisory Board;
2. the Conversations Group pilot, developed to the point where the model, facilitator training framework and safeguarding protocols are replicable by community and third-sector organizations independently;
3. the proposed conference and initial stakeholder engagement, through which the Disclosure Preparedness Advisory Group will begin to be constituted; and
4. engagement with governments, health departments and professional bodies to seek recognition of disclosure preparedness as a legitimate public health planning challenge.

Everything else proposed in this report – the simulation exercise, research program, practitioner CPD, formal advisory body, triage pathway, and messaging frameworks – will require contributing partners and funding.

The first concrete step in building that coalition is a proposed cross-sector conference planned for the United States in late 2026, with linked UK participation. Organizations with the capacity, mandate and resources to take the lead on specific workstreams are invited to contact uNHIdden. The action program is set out in Section 9.2.

9.2 Action summary and foundational actions

The table below summarizes the full action list. Actions are drawn from Sections 6, 7, 8 and 9,1, grouped by function rather than chronology, with a fourth category covering funding. The four functional categories are:

A. Facilitative actions
B. Shifting the mean (building ontological resilience)
C. Surge readiness
D. Funding.

Several actions will advance concurrently. The conference will be the first occasion at which sequencing, resourcing and workstream ownership are determined collectively rather than by uNHIdden alone.

Of all the actions listed below, four are foundational in the near term because they are the ones most likely to create irreversible momentum and make it progressively harder for the disclosure preparedness agenda to be ignored:

1. a funded research specification for ontological resilience, so that subsequent interventions are grounded in evidence rather than assumption;
2. a simulation exercise with at least one credible institutional co-orgaziser, which legitimizes everything else being done;
3. a cross-sector conference at which workstream leads are identified, the foundations of the Disclosure Preparedness Advisory Group are laid and the coalition becomes real rather than aspirational; and
4. at least one government or professional body having formally engaged with the question of disclosure preparedness and committed to further consideration.

These correspond broadly to actions A3, A4, A5 and A6 in the table below. All other actions referenced in the table below represent important investments in a more resilient and comprehensive response to disclosure, but these four foundational actions establish the disclosure preparedness program as real rather than aspirational.

Ref	Action	Who should lead?
A. Facilitative actions		
A1 - Reduce	Develop a program to measure and reduce stigma around serious engagement with anomalous experiences and paradigm-shifting information. Baseline measurement before interventions begin is essential to track progress and evaluate impact.	Academic and public health institutions to design measurement tools and evaluate impact; non-profit organizations with experience of stigma-reduction campaigns to lead delivery; uNHIdden to initiate and co-design.
A2- Conversations group model	Develop the conversations group model: a facilitator training framework with safeguarding protocols – including duty of care to participants, escalation rules, supervision and monitoring - replicable by community and non-profit organizations without extensive setup.	uNHIdden to develop and pilot the model; legal advisers and safeguarding specialists to advise on duty of care, consent and data protection frameworks; community and non-profit organizations to replicate at scale.

Ref	Action	Who should lead?
	Legal and ethical assessment of the model, covering data protection, consent and liability, should be commissioned before scaled deployment. Pilot through the uNHIdden Conversations Group and develop to the point where other organizations can adopt and run groups independently.	
A3 - Research ontological shock	Commission research into the psychological and social mechanisms that support or undermine ontological resilience, and develop measurement approaches capable of establishing a baseline and tracking whether interventions are working.	Academic research institutions and public health research bodies to design and conduct; research councils (Wellcome Trust, ESRC, NIH equivalents) to fund; uNHIdden to develop the initial specification and identify commissioning partners.
A4 - Simulation exercise	Run a structured simulation exercise testing preparedness across a range of plausible disclosure scenarios - gradual, abrupt and ambiguous - to identify gaps in existing planning and build the relationships and shared understanding that effective response requires. The output - a formal after-action report - provides the evidential foundation for subsequent engagement with health systems and national risk planning processes.	An emergency planning institution or academic public health unit with appropriate standing to design and facilitate; uNHIdden to develop the case, identify partners and secure funding; government emergency planning teams and health system representatives to participate.
A5 - Convene conference	Convene a cross-sector conference to stress-test this report's analysis, identify workstream leads and begin building the delivery coalition. Planned for the United States in late 2026, with linked UK participation.	uNHIdden to initiate and convene; a US academic or public health institution as co-host preferred; participating organizations to commit to specific workstreams at or following the conference.

Ref	Action	Who should lead?
A6 - Institutional engagement	Engage governments, health departments and professional bodies to seek recognition of disclosure preparedness as a legitimate public health planning challenge. The ask is not endorsement of any view on the probability of disclosure, but acknowledgment that current frameworks are unprepared for its consequences.	uNHIdden to initiate and develop briefing materials; relevant bodies in the US (HHS, CDC, FEMA, APA, ACA, AAFP) and UK (DHSC, UKHSA, Cabinet Office, RCPsych, BPS, BACP, RCGP) to respond and engage.
B. Shifting the mean - building ontological resilience (population-wide prevention)		
B1 - Reduce ontological shock	Develop and deliver a program of interventions to reduce adverse responses to paradigm-shifting information at population scale, drawing on the evidence base established under A3.	Academic research institutions and public health bodies to design and deliver; Wellcome Trust, ESRC, NIH equivalents to fund; uNHIdden to develop the initial specification and identify commissioning partners.
B2 - Engage delivery partners	Engage organizations embedded in each relevant community to ensure that support resources are appropriate, credible and acceptable to each group, and to lead their delivery. Partners should be involved in design from the outset rather than presented with finished materials for endorsement.	A public health or clinical organization with resource development capability to lead design in partnership with community organizations; uNHIdden to initiate and facilitate relationships; interfaith organizations and faith leaders for religious communities; learned societies for STEM professionals; community organizations for vulnerable populations; experiencer networks for experiencers.
B3 - Experiencer support	Create the conditions in which people who have had anomalous encounters can share their experiences seriously and without stigma. The primary purpose is care and validation. Identify and support organizations willing to provide credible, clinically grounded experiencer support beyond the uNHIdden Conversations Group pilot.	uNHIdden through the Conversations Group pilot; clinical psychologists and counselors with relevant experience to provide oversight; other organizations to be identified through the conference and stakeholder engagement process.

Ref	Action	Who should lead?
B4 - Build trusted voice network	Build two distinct but related networks: a trusted voice network of credible public figures willing to engage seriously with paradigm-shifting questions pre- and post-disclosure; and a Disclosure Preparedness Advisory Group capable of providing authoritative independent guidance at the point of disclosure.	uNHIdden to develop terms of reference and selection criteria; an independent governance body to oversee recruitment and safeguard independence; academic institutions and professional bodies to identify and support participating individuals; the conference (A5) the primary occasion for constituting the DPAG.
B5 - Clinical recognition	Seek recognition of psychological responses to paradigm-shifting information as a legitimate area for clinical research and study - not the creation of a new diagnostic category, but acknowledgment that these responses warrant clinical attention and that validated therapeutic approaches need to be developed. This recognition is the enabling condition for the practitioner CPD program in C2.	American Psychiatric Association; American Psychological Association; American Counseling Association; Royal College of Psychiatrists; British Psychological Society to consider and respond; uNHIdden to make the case and provide supporting evidence as part of the broader stakeholder engagement under A6.
C. Surge readiness (targeted response)		
C1 - Self-help resources	Develop and finalize the suite of self-help resources required for immediate distribution at the point of disclosure: the uNHIdden wellbeing support guide, designed to help individuals manage anxiety and disorientation; and group-specific support resources for the high-risk groups identified in the HNA. All resources must be in tested, final form before any disclosure event.	uNHIdden for the wellbeing guide, subject to Medical Advisory Board sign-off; a public health or clinical organization with resource development capability for group-specific resources; distribution partners to disseminate at disclosure.

Ref	Action	Who should lead?
C2 - Practitioner CPD	Develop a continuing professional development module equipping therapists, counselors and general practitioners to recognize and respond to the psychological effects of paradigm-shifting information, framed broadly to include disclosure scenarios alongside other civilization-scale revelations. To be delivered through existing CPD systems. Clinical recognition under B5 is the enabling condition for this work.	British Association for Counseling and Psychotherapy; British Psychological Society; Royal College of General Practitioners and US equivalents to develop and embed in CPD systems; academic clinical partners to provide evidence base; uNHIdden to develop initial specification.
C3 - Scale conversation groups	Scale the conversation groups model developed under A2 across multiple settings so that it can be activated rapidly as community support infrastructure at the point of disclosure. Pre-disclosure, the same groups build ontological resilience; post-disclosure, they become the primary community support mechanism without requiring setup from scratch.	uNHIdden to maintain the replicable model and safeguarding framework; community and non-profit organizations to adopt and run groups at scale.
C4 - Mental health triage	Develop and test a triage protocol to identify the small minority of people whose response to disclosure crosses into clinical mental health territory and route them rapidly into appropriate care, including assessment and referral pathways for those presenting elevated risks of harm to themselves or others. Must be developed and tested in advance, compatible with existing emergency mental health frameworks.	SAMHSA and equivalent partners; NHS England; integrated care boards to own, develop and operate; local resilience forums to integrate into emergency planning; uNHIdden to initiate the conversation and make the case for development.

Ref	Action	Who should lead?
C5 - Deploy trusted voice network	Ensure the trusted voice network and the Disclosure Preparedness Advisory Group developed under B4 are briefed, prepared and ready to provide credible independent commentary from the moment of disclosure, including as a rapid response capability to counter misinformation. Develop group-specific messaging frameworks in advance for the communities most likely to need them.	The independent governance body overseeing the trusted voice network and DPAG to ensure readiness; uNHIdden to develop messaging frameworks in partnership with relevant community organizations; participating individuals and institutions to commit to availability at the point of disclosure.
D. Funding		
D1 - Secure funding	Secure the philanthropic and research funding without which the program cannot be fully delivered. Research and simulation are the most likely early attractors of institutional funding; the conference (A5) is the first opportunity to begin building a funding coalition.	uNHIdden to lead funder identification and relationship development; philanthropic funders with interests in mental health, existential risk, science communication and public health preparedness; research councils including Wellcome Trust, ESRC and NIH equivalents; government health departments for research and simulation components.

Table 4: Disclosure preparedness action summary

9.3 Governance, resourcing and next steps

The disclosure preparedness program requires governance commensurate with its ambitions and risks. In its current form, governance rests with uNHIdden's trustees, its OSAG and Medical Advisory Board. As the proposed program develops and partners engage, a steering group drawing on conference participants – with clear terms of reference, decision-making authority and accountability arrangements – will be the appropriate next step. This steering group is distinct from the Disclosure Preparedness Advisory Group described in Section 6.4, which serves as an independent expert body providing authoritative public guidance at the point of disclosure rather than as a program governance mechanism.

The steering group should develop and maintain a risk register – tracking reputational exposure, safeguarding risks, and the possibility that the framing is perceived as advocacy rather than precautionary public health – which should be reviewed regularly. Where assumptions embedded in the Theory of Change are not holding based on experience, the disclosure preparedness program must be adapted in real time.

The funding requirements are not uniform. Some elements will require only time and relationships with capable partners: stakeholder engagement, cross-sector convening and trusted voice network development. Other elements will require modest funding – facilitator training, and the wellbeing guide and conversations group pilots – through to those that will require significant investment – the simulation exercise and the research program. Funders with interests in mental health, existential risk, science communication, public health preparedness and community resilience will find elements of this program aligned with their priorities. Research and simulation are the most likely early attractors of institutional research funding.

The proposed disclosure preparedness program's effectiveness will be evaluated against the Theory of Change set out in Section 5, using the measurement frameworks developed under actions A1 and A3 listed in the table above. In the event of high-impact disclosure, the evidence collected in the post-disclosure period will be of significant public health value - there would be an obligation to collect evidence responsibly, analyze it rigorously and make it available to the public health and research community.

Many of the capabilities the program requires - improved public communication under uncertainty, strengthened community resilience, better integration of mental health into emergency preparedness - have value well beyond UAP disclosure scenarios. This is an investment in general resilience infrastructure. The success of the framework will be measured not by any single organization's delivery, but by whether - if high-impact disclosure occurs - the population is meaningfully better prepared than it would otherwise have been.

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Appendix B: List of abbreviations

Abbreviation	Full term
AARO	All-domain Anomaly Resolution Office
ACA	American Counseling Association
AAFP	American Academy of Family Physicians
APA	American Psychiatric Association
BACP	British Association for Counseling and Psychotherapy
BMA	British Medical Association
BPS	British Psychological Society
Cabinet Office	Cabinet Office Resilience Directorate
CDC	Centers for Disease Control and Prevention
CPD	Continuing professional development
DHSC	Department of Health and Social Care (UK)
DoD	Department of Defense (US)
DPAG	Disclosure Preparedness Advisory Group
EPRR	Emergency preparedness, resilience and response
ESRC	Economic and Social Research Council
FEMA	Federal Emergency Management Agency
FOIA	Freedom of Information Act
GP	General practitioner
HHS	Department of Health and Human Services (US)
HNA	Health needs assessment
MAB	Medical Advisory Board
NATO	North Atlantic Treaty Organization
NHS	National Health Service
NHI	Non-human intelligence
NIH	National Institutes of Health
NSRA	National Security Risk Assessment
ONS	Office for National Statistics
OSAG	Ontological Security Advisory Group
PHEP	Public health emergency preparedness
PTSD	Post-traumatic stress disorder
RCGP	Royal College of General Practitioners
RCPsych	Royal College of Psychiatrists
SAMHSA	Substance Abuse and Mental Health Services Administration
SETI	Search for Extraterrestrial Intelligence
STEM	Science, technology, engineering, and mathematics
THIRA	Threat and Hazard Identification and Risk Assessment
ToC	Theory of Change
UAP	Unidentified Anomalous Phenomena
UFO	Unidentified Flying Object
UK	United Kingdom
UKHSA	UK Health Security Agency

uNHIdden is a clinically-led non-profit organization supporting the health, mental health and public health aspects of exceptional experiences and disclosure.

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