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LITERATURE AND BEST PRACTICE REVIEW AND ASSESSMENT:

IDENTIFYING PEOPLE'S NEEDS IN MAJOR EMERGENCIES AND BEST PRACTICE IN HUMANITARIAN RESPONSE

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Author's biography

Dr Anne Eyre is a sociologist by background and left an academic career in 2001 to run her own business providing independent research, training and consultancy. She specialises in the humanitarian dimensions of emergency planning and response and works with a range of organisations developing psycho-social planning, training and response strategies for major emergencies.

Anne belongs to a number of national and international research and practitioner organisations specialising in disaster management. This includes serving on the Board of Directors of the Association of Traumatic Stress Specialists and being joint Vice-Chair of Disaster Action. She also convenes the Disasters Study Group established through the British Sociological Association. Anne has published widely in both academic and practitioner journals.

In 2006 Anne was awarded a Winston Churchill Travelling Fellowship and travelled to New York to examine community support after disasters. A copy of her report is available at www.wcmt.org.uk/public/reports/60_1.pdf

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Executive Summary

This report provides an independent, comprehensive review of evidence about provisions and interventions to meet the needs of people affected by emergencies as defined within the Civil Contingencies Act (2004). Drawing on an extensive range of information, based on both historical and contemporary research and practice, the analysis presents an assessment of people's psycho-social needs following events such as natural disasters, terrorism and other major incidents. Though some reference has been made to evidence about the needs and consequences of responding to these events on disaster workers, the main emphasis here is on those directly affected as bereaved people and/or injured survivors. The report offers best practice guidelines based on the most effective methods of humanitarian assistance in the immediate, short-term and longer-term aftermath of major emergencies.

Both domestic and international empirical evidence has been drawn on in a literature review spanning a range of disciplinary sources, including psychological, sociological and social work-based approaches. The emphasis is more on common findings of psycho-social issues across disasters rather than than an analysis of specific incidents or events, though some illustrative examples of models of intervention following particular events is included. As well as academic articles, accounts and reports by those providing and using services have been referred to. A discussion about the quality of programme evaluations and the appropriateness of generalising lessons and recommendations from particular events and differing sources is included in the analysis.

Key findings include the fact that the psychological and social impacts on those affected by major emergencies are many and varied. As well as including grief, trauma, stress and other forms of loss-related reactions, the evidence suggests that people are generally resilient and demonstrate the ability to adapt, adjust and recover after such events. The ability to cope is related to a range of pre-disaster, within-disaster, and post-disaster risk factors. Information and activities which normalise reactions, protect social resources and signpost further sources of support are fundamental to good psycho-social response.

Forms of humanitarian assistance and intervention have varied considerably over time, place and incident, reflecting in part a developing understanding of the psycho-social impacts of disasters and lessons learned about the best ways of addressing people's needs. Proactive outreach, including personalised support for bereaved families and contact between those affected, has been found to be most helpful from the earliest stages. The emphasis on interventions should be on empowerment, that is to say drawing upon resilience and building strengths, capabilities and self-sufficiency while at the same time making available appropriate mental-health and other services that complement individual, family and community-based coping strategies. Providing psycho-social support includes facilitating opportunities for those seeking out others to have the opportunity to be in contact and meet informally as soon as possible after the event.

An obvious recommendation from a review such as this is for more and better planning. This report aims to go further than just suggesting the need for further humanitarian assistance planning, fundamental though this activity is. It includes a discussion of why it is often the case that lessons fail to be learned or applied in effective planning and response for psycho-social support after

fail to be learned or applied in effective planning and response for psycho-social support after disasters. The reasons include the fact that emergency planners often base their efforts on myths about human behaviour and reactions during and after disaster. Other common pitfalls, such as fragmented approaches to mental health and social support, and a tendency to see disaster planning as a product rather than a process, are highlighted along with the implications for good practice to overcome such weaknesses.

Throughout the report, key points are summarised at various intervals and suggestions for further reading are highlighted. A summary of best practice guidelines is produced at the end of the report and, for ease of reference, is included again along with a summary of the key points as a separate appendix (Appendix 3). A full list of all references used in the review is included at the end of the report.

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Introduction

> 'The acute disastrous circumstances of major catastrophes represent much of our struggle to deal with the stresses of existence. As such, they symbolize and condense many factors important to understanding human behaviour and alleviating human suffering. The death and devastation of disaster represents the worst of human fears' (Raphael 1986:4)

This review provides an assessment of domestic and international evidence about provisions and interventions to meet the needs of people affected by emergencies such as natural disasters, terrorism or other major incidents. It includes both those recent disasters affecting UK citizens occurring on UK soil and those incidents abroad affecting UK citizens. Regardless of where incidents occur, there are some common initial, medium and longer term effects that are discussed here with reference to the practical implications for those planning and providing humanitarian response. Particular emphasis is placed in this report on psycho-social needs and the different types of interventions and provisions which experience has shown to be effective in addressing needs over time. Based on the evidence available, an assessment has been made of the most effective methods of intervention and guidelines for best practice are included.

Following the **methodology section** the review of key evidence and best practice is set out as follows:-

Part I discusses the **nature and types of major emergency** included in the review as based on the definition of 'emergency' defined within the Civil Contingencies Act 2004. Evidence of who is affected by events is referred to here, including common risk factors for individuals and the communal dimensions of disasters. The importance of evidence-based disaster management is discussed and common myths about disaster-related behaviour are highlighted in order to inform more effective psycho-social planning and response.

Part II identifies the typical **emotional impacts and reactions** following an incident. The wide-ranging nature of psychological need during and after emergencies is acknowledged with a specific focus on those generated by bereavement, trauma and other forms of loss. The value of understanding and responding in relation to phases or stages of impacts is introduced, while at the same time an approach that is responsive to the needs of individuals rather than being overly prescriptive is emphasised. Appropriate interventions are referred to based on the latest evidence-based guidelines for dealing with phenomena such as Post Traumatic Stress Disorder (PTSD).

Part III examines different **types of organisational provision for meeting people's needs** following major incidents. A model of provision is presented with reference to a phased approach based on a timeline of impacts and interventions. Specific forms of response are discussed and lessons learned from previous experiences of service provision are identified from existing literature. In recommending particular forms of support, the reasons for their inclusion and ways in which they can make a difference in addressing needs are discussed. The significance of

understanding the context of disaster for psycho-social recovery and the role of legal processes such as public inquiries are highlighted.

Part IV reviews evidence of **particular models of service** that have been provided following some specific incidents as the basis for the best practice guidelines that follow. Information about the type of service, the way in which it was organised and how it was delivered is detailed, along with lessons learned. The background to and examples of differing forms of 'one-stop shop' models are included here, such as those provided after the disasters at Dunblane and, more recently, after the September 11 attacks and the Asian Tsunami.

Parts V and VI draw together the implications of the review for best practice in responding to meet the needs of people affected by future incidents. **Common pitfalls in planning and response** are outlined along with suggestions for avoiding these. Finally **recommendations for best practice** are summarised, based on the evidence and analysis.

Throughout the review, key points are summarised and suggestions for further reading indicated. A **full list of references** is included at the end of the review.

Methodology

There is a vast amount of literature available about provisions and interventions to meet the needs of people affectd by emergencies. To meet the particular requirements of this review, the criteria for selecting sources included their relevance to discussing the psycho-social impacts of emergencies (as defined within the Civil Contingencies Act 2004), the needs of those affected and models for humanitarian assistance. Though some reference has been made to evidence about the impact of responding on disaster workers, the main emphasis has been on those directly affected as bereaved people and/or injured survivors.

Both domestic and international empirical evidence has been drawn on spanning a range of disciplinary sources, most commonly psychological, sociological and social work-based approaches. As anticipated there were variations with regard to the extent to which empirical research and scientific evidence was available to address the comprehensive range of questions identified in the tender specification. For example, there is much research and information available about both the needs of different people affected by incidents and critical assessments of particular types of intervention such as psychological debriefing, but less good, comprehensive evidence-based research and evaluation available in relation to the effectiveness of other forms of post-disaster service.

As well as academic studies, accounts and reports by those providing and using services have been referred to. Where there is evidence available relating to end-users' experiences and evaluation of services this has been included. Much of this has tended to be anecdotal and unrepresentative though, making it difficult to generalise about the overall effectiveness and costs/benefits of provisions using this material alone. A number of researchers have highlighted the lack of sophisticated evaluation as problematic either in relation to particular programmes or the field of disaster research in general. For example Call and Pfefferbaum (1999) refer to one of the shortcomings of Oklahoma's Project Heartland being 'a failure to systematically and contemporaneously evaluate its effectiveness. Therefore, the lessons learned in the process are anecdotal'. Equally this criticism could be applied to many of the initiatives reviewed here and leads to the recommendation in Part VI calling for better programme evaluation methods in future.

Exceptions to these methodological shortfalls include the comprehensive inventory of research findings conducted by Drabek (1986) which represents one of the few sophisticated, systematic

reviews conducted in this field. For this reason, although some of the references he cites appear dated, they are included because of the scale of the reviews, the scientific status of the research and the continuing relevance of their findings today. The recent and equally systematic empirical review conducted by Norris et al (2002 and updated in 2005) is also referred to here. This work complements historical findings with the latest results on the mental health effects of disasters based on an extensive analysis of the disaster literature.

Notwithstanding this, the review has inevitably reflected the fact that different standards for analysis exist between research-based studies and practitioner-based accounts of post-disaster interventions. Even within the social scientific literature and research community this has long been problematic (Drabek 1986:14) and reflects in part the limitations relating to the nature of the aftermath of disasters including the lack of good control of variable selection, poor record keeping by responders during disasters, and the paucity of disaster research making it into peer-reviewed journals (Auf der Heide (2005)).

As well as differing standards of analysis, the range of disciplines drawn on here tend to generate different types of data. Those seeking statistical data and a quantitative approach may wish to look at the rigorous types of sampling, coding and regression analysis typified by studies of PTSD such as Norris' 2005 analysis of the range, magnitude and duration of the effects of disasters. In many psychological-based studies, numerical evidence is more common (see for example Marshall et al's summary of research citing statistics on PTSD rates following September 11 attacks (2006:4) and Rose et al's 2002 review of evidence based on random controlled trials testing the efficacy of debriefing and the development of PTSD. In other areas of research covered by this review, qualitative approaches are more common (see for example Eyre 1998). The nature of the subject under review here suggests that both forms of approach and types of data offer value in understanding the effects of disasters and informing the development of policy across organisations wishing to adopt a holistic approach to dealing with disasters as opposed to either a purely quantitative or qualitative approach.

In terms of data-gathering techniques for this review, as well as library sources a number of general internet-based search engines and research databases were referred to such as Copac, BUBL (Bulletin Board for Libraries) and SOSIG (the Social Sciences Information Gateway). Specialist search facilities were also used to identify international research literature and research by particular events and case studies. These specialist facilities included a number of contemporary internet-based forums, newsletters and journals. Full details of the references used are included at the end of this report.

Part I: The Nature and Types of Emergency Events

Defining Emergencies and Disasters

There are many different terms used to describe emergency situations and it is important to be clear about the types of events included in this review. The differing terminology often employed reflects not only differences in terms of cause, scale and impact of events, but also the differing perspectives and approaches of those defining them. This is important because it highlights the fact those fulfilling the range of strategic and operational roles and responsibilities in the aftermath of incidents will have different, and sometimes conflicting, interests and priorities.

Thus for example, small scale incidents termed 'accident' and routine 'emergency' are likely to involve injury or ill health to a small number of individuals and/or modest damage to physical structures. They are likely to be unexpected events which could place life and/or property in danger

and require an immediate response but usually through the use of routine community resources and procedures (Drabek (1996)). Events which are 'mass emergencies' or 'major incidents' on a larger scale will likely require the resources from across a number of departments or organisations, and assistance from agencies outside of an area or region may be needed.

The emergency services' definition of a 'major incident' below reflects the scale and impact of such an event and the practical implications for collective response across differing organisations:

'A Major Incident is an emergency that requires the implementation of special arrangements by one or all of the emergency services for:

- The rescue and transport of a large number of casualties.
- The involvement, either directly or indirectly, of large numbers of people.
- The handling of a large number of enquiries, usually to the police, from the public and the news media.
- Any incident that requires the combined resources of the three emergency services on a large scale.
- The mobilisation and organisation of the emergency services and supporting organisations e.g. Local Authorities, to cater for the threat of death, serious injury or homelessness to a large number of people' (ACPO 1999).

More recently the Civil Contingencies Act (2004) has discussed the sorts of events embraced under the umbrella terminology of 'emergency' as covered by this new landmark piece of legislation influencing today's emergency planning and response. Developed against the backdrop of the experience the fuel crisis, the outbreak of Foot and Mouth Disease, Floods, Fires and the terrorist attacks of September 11 2001, 'emergency' is defined within the Act as:

'An event or situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK' (2004).

Whatever terminology is used and for whatever types of event, it is important to remember that all such incidents are not only physical events requiring procedural approaches to planning and response; they are also *psychological* and *social* events. It is these dimensions of their cause and impact which are considered specifically in this review. Saylor (1993) reflects this approach in highlighting that, while the definition of a 'disaster' varies with the source and purpose, there is a general consensus that a disaster is an event that involves the destruction of property, injury, and/or loss of life; has an identifiable beginning and end; adversely affects a relatively large group of people; is 'public' and shared by members of more than one family; is out of the realm of ordinary experience; and psychologically, is traumatic enough to induce distress in almost anyone.

In recent years researchers and practitioners have discussed the impact of catastrophic or calamitous events which, though rare, are significant in impact. These are events in which a society incurs, or is threatened to incur, such losses to persons and/or property that the entire society is affected and extraordinary resources and skills are required, some of which must come from other nations (Drabek (1996)). Historical examples of this include the Black Death or, in terms of its impact over time and place, the ongoing AIDS epidemic. More recent examples also include the Asian Tsunami of 2004, whose impact extended over time and many nations, thus making it a global disaster.

Quarantelli (2006) argues that we are now at historical juncture with the appearance of a new category of disasters, referred to as 'trans-system social ruptures' (TSSR). This label tries to indicate that these kinds of disasters jump to or cut across different social systems; examples include the spread of the Severe Acute Respiratory (SARS) and the SoBig computer F virus, both in 2003.

This review covers events which go beyond the ordinary in terms of scale and impact, i.e. those defined under the terms major incident, major emergency or disaster (these terms are used interchangeably throughout this review). However, much of what is discussed below may well be relevant to personal 'disasters' too, as experienced by those bereaved and injured individuals and their families, such as those affected by road death (a global disaster in terms of the scale and impact over time and place). Indeed, a key theme in this review is the importance of addressing the relationship between disaster planning and response and everyday planning and provision for those in psycho-social need in our society and the importance of continuity where possible in identifying, acknowledging and addressing need.

Dimensions and Elements of Disaster

Some writers have sought to depict differing dimensions of disaster events pictorially. Gibson (1994), for example, developed a grid illustrating elements of disaster for use by those planning provision for the psychological needs of those affected. The grid identifies some of the main variables common to all incidents, though Gibson comments that consideration of these variables can determine elements that contribute to the uniqueness of a single event (1994:134).

	Natural			Man-made		
Personal						
	Small	Medium	Large	Small	Medium	Large
Local						
National						
International						

(Elements of Disaster - Gibson 1994:135)

Attempts to fill in the grid with reference to examples of disasters illustrates how complex and subjective the experience of disaster is; for example the distinctions between 'natural' and 'man-made' events are far from straightforward. Those regarding the authorities at fault (who failed to plan and implement early warning systems before the Asian Tsunami of 2004) may differ in their analysis of that event from those who saw it as a 'natural' and unpreventable disaster. These distinctions are not just academic but make a difference in terms of the psychological meaning of the event, its causes and consequences. For those who are bereaved and/or survivors from such events recovery may be integrally linked to the availability of answers to questions such as how and why these events happened, the opportunities for lessons to be learned and the chance of similar events being prevented in future.

Note 1 gives details of a database of Major Incidents as compiled by the Emergency Planning College (www.epcollege.gov.uk/library_and_information_centre/index.shtm). Most of the events deemed major incident or disasters on the database have occurred within the UK and were experienced as sudden and unexpected events. This makes a difference in terms of their impact and the implications for psycho-social support following their occurrence. That is to say, as opposed to events with prior warning (such as in the US where hazards like hurricanes and tornadoes are easier for local agencies to predict and follow up with warnings, risk communication and evacuation), in the UK warning signs may be less obvious or less heeded, such that events appear to occur out of the blue and causal factors remain unaddressed until after disaster strikes. Where analyses of human causation and accountability follow these usually entail lengthy and drawn out processes of investigation and inquiry. These political elements of the disaster experience and its longer term aftermath impact on the understanding, interpretation and ultimately the experience of disaster by all those involved. As is discussed in more detail later, psycho-social planners must take account of this social and political context of disaster when planning and implementing any response.

Disasters as International Events

In many, if not most, cases today a major disaster is likely to include an international dimension. Where an incident involves those undertaking international travel the likelihood of global impact may be even higher; in the Lockerbie disaster 21 nationalities were involved and in the Asian Tsunami, many of the deceased in countries such as Thailand and Sri Lanka were travellers and tourists from across Europe.

Reflecting on her experience of responding to the M1 plane crash, Gibson writes about the implications of location for post-incident support. This is relevant to any type of mass emergency, not just those involving transport incidents:-

'..Disasters may happen in a location far removed from the homes of those most affected. Help will be needed at the location of the accident but longer term help may be needed in the home towns of those affected. This can have major implications in terms of resource allocation in areas not seen to be the site of the incident. Thus the local, national, or international nature of the disaster is a significant determinant in the type of response that will be required' (Gibson 1994:136).

Thus aspects of the geographical location of an incident need also to be considered when planning and providing for those affected by disaster. The needs of those UK citizens involved in events occurring outside of the UK are included in this review and its recommendations. Indeed the statutory requirements of the Civil Contingencies Act apply even if an emergency happens outside of the UK. Even in domestic incidents, the impact is likely to be far-reaching in terms of those affected both directly and indirectly. Of the seven fatalities from the Potters Bar rail crash, 2002 for example, families of four of the deceased were either from, or had close family connections, outside of the UK.

Where an event occurs outside of the UK victims may not have access to the same kind of support mechanisms available domestically. This not only includes immediate practical and emotional support, but also familiarity with language and cultural arrangements as well as access to financial support mechanisms such as compensation and insurance, particularly if an event is, for example, caused by terrorism. Families affected by recent events such as the Sharm-el-Sheikh (2005), Turkey (2003) and Bali (2002) terrorist attacks became acutely aware of the differential systems of support available after such incidents and have called for this to be addressed (TROMBONES petition - The Relatives Of Murdered Britons Overseas Needing Emergency Support:

http://www.gopetition.co.uk). In recognition of the need for this situation to be reviewed, special measures for addressing the needs of those affected by terrorism are being discussed in various current forums (e.g. activities in members states in response to Article 10 of the EU Council Framework Decision on combating terrorism, 13 June 2002, which requires that measures should be taken to ensure appropriate assistance for victims and their families). It is suggested that such work should be discussed and integrated into further work developing from this review.

The location where a disaster occurs can also affect, for good or ill, perceptions of where help should be offered and by whom. After the Piper Alpha explosion, for example, the incident was seen as something that had happened in the North Sea and many people perceived it as therefore only affecting those in the north of Scotland (Bone 1996:26). As well as addressing what is often a misperception, efforts must be made to proactively identify all those affected by an incident wherever they may be, a difficult task given that this is likely to extend well beyond the exact site of an incident. Even capturing details of those present at a particular site has been found to be difficult if efforts are not made immediately.

As well as considering the regional and national coordination of psycho-social support within the UK, therefore, the relationships and liaison between disaster services across different countries must also be considered alongside the role of government departments such as the Foreign & Commonwealth (FCO) Consular Directorate and local consulate offices/embassies at the planning and response stages. Aspects of the FCO's new work on Rapid Deployment Teams are referred to later in this review.

Marion Gibson explains how the relationship of helpers to the physical location of the incident can impact on the acceptability of help after disasters. Her comments are based on her Kegworth experience, but have wider relevance: 'Those who were recipients of help at the site may have difficulty in accepting help from those who were not involved at the time of the crisis. These features were experienced by the helping agencies in Northern Ireland following the M1 aircrash' (Gibson 1994:136).

Later we will discuss the implications of these extensive impacts across wide geographical areas for the establishment of groups and committees coordinating and managing post-disaster services. We will discuss the advantages and drawbacks of making available specialist services after an event as well as using responses that tap into existing support networks within communities.

Who is Affected by Disasters?

Because of their nature and scale, when disasters occur large numbers of people are likely to be affected, both directly and indirectly. Taylor and Fraser (1981) produced a classification of disaster victims using the imagery of a ripple effect of events based on factors such as proximity to the impact zone and psychological consequences of the disaster experience. Under this classification, potential victims include not only those directly injured (physically and psychologically) and those bereaved, but others who may be involved either as witnesses or responders, both in the short or longer term. This work highlights that the line between victims and non-victims is not as obvious as might at first appear and that beyond those who have been hurt physically - or who have incurred losses of possessions – are a wide variety of 'hidden victims'.

Many have adopted the analogy of the ever widening circles or ripple effect of such impacts and stressed the importance of acknowledging the practical implications of this for psycho-social planning and response. 'The number of those directly involved must be seen as a starting point only. The number of people affected by any disaster can be compared to the effect of dropping a pebble into a still pond of water. The ripples created in the water spread out in rings from the centre. The

effect of a disaster on people can also spread far beyond its epicentre' (Gibson 1994:137). The recent findings of Marshall et al (2006) reinforce the importance of going well beyond just the traditional 'bull's-eye model' in addressing the psychological effects of events.

Newburn (1996a) includes in the ripple effect the network of circles around both the bereaved (their neighbours/acquaintances, friends, relatives) and also around professional carers, (their relatives, colleagues and ex-colleagues, managers and supervisors of carers). Based on his research of care offered after the Hillsborough Disaster, he notes that family and personal relationships in particular can come under stress and emphasises that post-disaster social work services need to consider if and how they can intervene in ways that support relationships as well as individuals, both for professionals and non-professionals (1996a:15).

Newburn's work also highlighted the various ways in which the ripple effect of disasters are experienced and why it is important to think in terms of the social as well as psychological effects and implications of disasters. He documents how the Hillsborough Disaster (1989) had an impact on people's lives in five main ways: 'practically, emotionally, on behaviour, on relationships and on work' (1996a:15). He advises that while the emotional consequences of events are most usually discussed, given the catalogue of practical, psychological and emotional problems facing those affected by disaster, these elements ought also to be addressed in psycho-social response. This includes the implications for relationships: 'It is perhaps not surprising that considerable strain is often placed upon relationships, including work relationships…Many of those affected by the disaster found that their working lives were disrupted. Whilst employers were generally sympathetic to the need for compassionate leave in the immediate aftermath of the disaster, memories were short, and requests for leave at later dates did not necessarily receive a similar response' (1996a Newburn p16).

The value of work discussing these ripple effects is that they remind us of the importance of proactive outreach to groups of people involved directly and indirectly in disasters and not just those physically proximate to the site of an event. In this way they are helpful for considering practical outreach strategies and acknowledging that the nature and levels of support required may vary and should be adjusted accordingly. It is also important to be proportionate. It may, for example, be sufficient to acknowledge the fact that someone who did not travel on a particular train on a certain day (and thereby might have been involved had other circumstances prevailed), may feel understandably distressed at the thought that they could have been involved.

Given the nature of emotional reactions to disaster, we might well wish to blur the boundaries of the levels or categories in Taylor and Fraser's typology given that the status of those affected by disaster might overlap; for example the fire-fighters whose colleagues died in 9/11 would fit into several of their categories. Today our increasing understanding of trauma is leading to an acknowledgement that many different categories of people might be affected by events in many different ways, including the potential to experience post traumatic stress reactions (Marshall et al 2006).

We must therefore be wary of generalising and should approach the classification or labelling of victims with caution. The term *'victim'* itself has connotations which may conjure up images and unhelpful generalisations about passivity and helplessness. Helpers may adopt inappropriate or misguided expectations about victims' feelings, wants, needs and behaviour. One example of the implications of labelling is demonstrated by Walsh: 'Apart from the victim role of being weak and resourceless, they are often expected to be grateful for rescue and help. How do you express your grief, anger and distress as you need if the people helping you keep expecting you to be grateful?' (1989:93).

Furthermore, notions of differing categories or levels of victim may be used to suggest that an implicit or explicit 'hierarchy of grief' exists linked to the expectation that some victims are necessarily *more* affected or *worse off* than others. This may be based on unhelpful assumptions and it is inappropriate to expect that human responses to trauma work along such rational lines. Rather, as discussed below, researchers have suggested that susceptibility to post-trauma reactions is influenced by a range of other factors as well as the disaster experience itself. For these reasons it is unhelpful to equate the nature of disaster reactions simply with degree of proximity to the event and those wishing to understand and plan for psycho-social response should be wary of applying definitions and concepts of disasters and victims superficially and uncritically. This is also a key theme throughout this review which promotes a 'person-centred' or 'user-based' approach.

Communal Dimensions of Disasters

Individual and Collective Trauma in Disaster

Erikson (1976; 1991; 1994) reinforces the importance of understanding the grass roots social and collective experiences of disaster impacts. Based on his observation and analysis of a number of disaster-struck communities, he describes how those involved share an enormous experience and come to view the world around them in new and different ways. His writing makes much of the communal effects of disasters. Today our concepts of the nature of 'communities' affected by an incident might be even more extensive than ever and as much virtual as physical given the ever increasing power and reach of technologies such as the internet and satellite television.

Erikson (1994) writes of two types of disaster trauma: individual trauma (a blow to the psyche that breaks through one's defenses so suddenly and with such brutal force that one cannot react to it effectively) and collective trauma (a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality). Planning and interventions should consider the impact on and outreach to communities at large about both the personal and collective effects of disaster.

Identifying Vulnerable Communities

While all major incidents might be expected to have effects on communities, research and experience shows that some individuals or social groups may be more vulnerable to the impact of disaster than others and that it is possible to some extent to pre-identify such people ahead of disasters or soon after in considering outreach and response. In this sense the principles of risk assessment and management are particularly relevant to psycho-social planning and response.

In some types of disasters the challenge of identifying exactly who is involved and potentially in need of psycho-social support may be more problematic than in circumstances where the affected population is more obviously identifiable (for example by way of geography or confirmation of involvement). With some forms of transport accident, for example, passenger lists or 'manifests' are available or, in the case of a school or workplace incident, there may be student registers or lists of employees which can be consulted (even though confirmation of the accuracy of such lists often takes time). In other incidents, no such formal lists or evidence are available and the only way to know who might need or wish for support is to reach out and respond when people choose to access support mechanisms. Given that most people will not, for various reasons (as discussed below), request formal help after disasters and that for some people the emotional effects of their involvement in a disaster might not become apparent for some time after, it is often impossible to know the full extent of the ripple effect. This is likely to remain a challenge for anyone planning

and providing a response to disaster as was found to be the case by those responding to the needs of UK citizens affected by the Asian Tsunami (2004).

An example where impacted communities are able to be identified at the planning stage is in the case of air disasters. Organisations like the International Civil Aviation Organization (ICAO) have considered the particular needs of those affected by aircraft accidents and, following the adoption of a resolution in 1998, have recommended the development of policies and procedures for responding. Some countries, such as the US, have subsequently introduced legislation mandating airlines to plan for and provide forms of family assistance after aircraft accidents. ICAO (2001) has also produced a circular giving guidance on the types of family assistance that may be provided to aircraft accident victims and their families and the avenues available for providing that assistance (details of this are integrated into the discussion of particular forms of psycho-social support below).

Under the Civil Contingencies Act (2004) Category One responders are now required to maintain a Community Risk Register (CRR) as part of their local risk assessment process. This includes identifying the risks, consequences and significance of threats or hazards. However, because of the way the register is structured, impacts are likely to be expressed only in terms of the facilities that have been destroyed, the numbers of fatalities and casualties, or the extent of contamination rather than considering the broader potential ripple effects. Such an approach is unlikely to include assessment of the less tangible indicators of psycho-social risk and impact and thereby the implications for psycho-social planning and response discussed in this report. This is a significant deficit, especially given that writers on humanitarian need have long stressed the importance of going beyond physical indicators alone in assessing and responding to the impacts of disasters. Gibson, for example, higlights the difference between the nature and measurability of psycho-social impacts and the challenges they pose for recovery: 'Crashed aircraft are disposable, bombed buildings can be rebuilt, and burned out football stadia can be reconstructed. These results of disaster are visible, but the psychological trauma and effects on people's lives is less visible and may impede their normal functioning for a long period of time' (Gibson 1994:133).

The National Capabilities Survey (2006) issued by the Cabinet Office has asked responders (i.e. Government Departments, Executive Agencies, Local Councils, and private sector utility companies who form part of the Critical National Infrastructure) whether they have access to 'a register of vulnerable people within the local commuity who might have special requirements during an emergency'. It also asks whether responders are aware of other groups of vulnerable people who would not be included in these registers but might nevertheless have special requirements during an emergency. It will be interesting to see whether responders identify the sorts of individuals and groups detailed below in approaching the assessment of risk locally and the extent to which account is taken of the broader dimensions of vulnerability in pre-disaster psycho-social planning by those responders. More work may well be needed in this area and in relation to broadening the scope of the Community Risk Registers.

Risk Factors for Individuals

So far a community-based or user-based approach to understanding disasters has highlighted a most important point for anyone considering psycho-social planning and response, namely the fact that in any single event there will differential experiences and degrees of vulnerability to disaster impacts. The psycho-social elements of disasters and human responses to them only really began to be explored explicitly in the 1980s (Drabek 1986:200) but today there is extensive literature and evidence documenting the nature of vulnerability and the practical implications for disaster planning and response. In particular psychological research has contributed much to our understanding of risk factors for individuals and identified those more likely to be vulnerable to adverse stress reactions after traumatic events.

Elaborating on factors related to coping and resilience, studies have highlighted that certain events may not be stressful to the same degree for all involved. Rather, what makes an event stressful is the individual's appraisal of the event. This is influenced by personal factors as well as the particularities of an incident. The extent to which an individual feels supported also makes a difference, this being where both formal/organised and informal social networks within the community become significant.

Norris et al (2005) summarise the results of an empirical review of research published over the last twenty years on risk factors for adverse outcomes in natural and human-caused disasters. In presenting their results they differentiate between *pre-disaster*, *within-disaster*, and *post-disaster factors*. Key significant pre-disaster factors influencing post disaster outcomes were found to be: gender, age and experience, culture and ethnicity, socioeconomic status (SES) (as manifest in education, income, literacy, or occupational prestige), family factors (such as being married, being a parent and family conflict) and pre-disaster functioning and personality. Within-disaster factors include: the severity of exposure at the individual or household level (including, for example, the presence of bereavement, injury, life threat, separation from family, loss of property and relocation or displacement), and neighbourhood- or community-level exposure. Post-disaster factors influencing post disaster outcomes include levels of stress and psycho-social resources in the aftermath of disaster.

Norris et al (2005) qualify their findings by commenting that the research base is larger and more consistent for adults than it is for young people. They suggest that even for adults, more research on many of these topics would be useful and might alter the conclusions reached thus far. At present, however, their review of the literature yields the following conclusions:

- 'An adult's risk for psychological distress will increase as the number of the following factors increases:

    - Female gender
    - 40 to 60 years old
    - Little previous experience or training relevant to coping with disaster
    - Ethnic minority
    - Low socioeconomic status
    - Children present in the home
    - For women, the presence of a spouse, especially if he is significantly distressed
    - Psychiatric history
    - Severe exposure to the disaster, especially injury, life threat, and extreme loss
    - Living in a highly disrupted or traumatized community
    - Secondary stress and resource loss

- With a few modifications, primarily the deletion of age specifications and minority group status, this risk-factor model holds reasonably well for children and adolescents.
- Families are extremely important systems and it is most important that post-disaster treatment and intervention efforts be aimed at the family unit.
- Outreach efforts for intensive services should focus on areas of the community where at-risk individuals and families are most likely to live. Treatments and interventions known to be effective for them should be implemented. It is important to pay attention to issues of diversity. Less intensive services, such as support groups and psycho-educational programmes, may be adequate for groups at lower risk.
- It is important to provide support to the supporters in families, especially wives and mothers.

- Communities might want to encourage groups at very low risk, such as older adults and childless men, to assume a greater share of the burden for the community's recovery by volunteering and participating in paraprofessional activities'.

Psycho-Social Resources in the Aftermath of Disasters

Norris et al's review highlights that amongst post disaster factors influencing levels of distress after disaster, the nature and level of psycho-social resources have been found to be particularly significant across disasters. They distinguished between two types of resources: those that are threatened by stress (vulnerable resources) and resources that emerge in response to stress (emergent resources). Certain psychological resources (such as coping efforts, self-efficacy, mastery, perceived control, self-esteem, hope, and optimism) have been found to protect disaster victims, while social resources (such as 'social embeddedness' [the size, activeness, and closeness of the survivor's network], received social support, and perceived social support) are all critical for offering protection.

The implications for intervention which can be drawn from their results include community focused, family focused and individuals focused interventions. In particular Norris et al stress that, whether directed toward the community, family, or individual, 'the emphasis for interventions should be on empowerment, meaning they should draw upon and build strengths, capabilities, and self-sufficiency' (2005). Their recommendations are considered further in the analysis of implications for best practice discussed later in this review.

A Note on Children and Young People

Reviewing historical research, Drabek (1986:271) reports how historically researchers emphasised the resiliency of children caught up in disaster (Perry, Silber and Black (1956)), especially if their families were strong and remained a source of social support. This was reinforced by the work of Kinston and Rosser (1974), again based on an extensive literature review and levels of understanding at the time:-

'The general conclusion is that children rarely need specialist psychiatric treatment but that they would benefit from an opportunity to ventilate their anxieties to a sympathetic adult. Those most at risk are between 8 and 12 years, have a previous history of physical or emotional illness and come from unstable homes' (1974:445).

In the mid-1970s however, the tone began to change as researchers began to scrutinise the matter more carefully. Certain elements, especially fears of subsequent events and sleep disturbances, began to be reported. In particular, separation from parents was identified as having potentially severe consequences for children.

However, even with the formal recognition of Post Traumatic Stress Disorder (PTSD) as a psychiatric diagnosis in 1980 little was known at that time about what disorders like PTSD looked like in children and adolescents. Gibson reflected on the limits of understanding that was available in the UK during the 1980s:

'Following disasters children's needs are often underestimated or neglected. Adults, struggling to come to terms with effects of trauma, may be unable to give their usual attention to children' (Gibson 1994:143).

Today there is much better understanding of the effects of disasters on children and young people, including their susceptibility to extreme reactions such as PTSD, and child-focused interventions

are more likely to be included in response strategies. In the recent aftermath of the Indonesian earthquake at Yogyakarta (2006) for example, special resources such as children's centres have been recognised as a key element of humanitarian response.

In planning for and providing psycho-social support, psychologists today stress that children can only comprehend the long-term effects of the disaster at their own level of experience and understanding. Thus guidelines on interventions highlight the importance of addressing their needs appropriately and with the assistance of specialist support and advice as necessary. Such considerations should be included into psycho-social planning, training and response which should engage those professionals working with children and young people within the community, such as teachers, educational psychologists and youth workers, before as well as after incidents occur.

Key Points

- Disasters are about people and responding to disasters – pre, during and post impact – is about *managing and supporting people*
- Whatever definition is used, all major emergencies are not only physical events but also *psycho-social events* involving people.
- The relationship between disaster planning and response and procedures and provision for meeting everyday need in society should be understood and addressed by anyone involved in providing humanitarian assistance.
- Current initiatives examining the implications of terrorism and the role of services provided internationally (such as through the Foreign & Commonwealth Office) should be considered alongside the recommendations of this review.
- Analysis of the ripple effects of incidents reminds us to consider the broad implications of events while also addressing differential levels of risk in relation to particular individuals and communities.

Further Reading

Hamblen J (2005) PTSD in Children and Adolescents: A National Centre for PTSD Fact Sheet

National Child Traumatic Stress Network – www.nctsnet.org (This is a national US-based website). Includes resources to help families and professionals be ready for, respond to and recover from disasters, including terrorist events)

Smith, P Dyregrov, A & Yule, W (1999). Children and Disaster: Teaching Recovery Techniques. Children and War Foundation, Bergen (http://www.childrenandwar.org/)

Beyond the Myths: Behaviour and Needs in Emergencies

Disaster policies, plans and procedures are more likely to be appropriate and successful if they are based on experience and evidence about how people typically behave and respond in the impact and

aftermath phases of disaster. However researchers have long observed that planners may be basing their efforts on myths about human behaviour with the result that they are more likely to be ineffective (Drabek 1986:47). From an extensive review of emergency plans Drabek concluded that they generally included almost no expectations for public behaviour during a disaster. Furthermore, when attention is given to public response, it is generally predicated on erroneous conceptions of public behaviour.

More recently Eric Auf der Heide, a renowned medical expert and writer in disaster preparedness and response planning, has reinforced this observation:

'Disaster planning is only as good as the assumptions on which it is based. However, some of these assumptions are derived from a conventional wisdom that is at variance with empirical field disaster research studies. Knowledge of disaster research findings might help planners avoid common disaster management pitfalls, thereby improving disaster response planning' (2005).

Auf der Heide highlights the importance of disseminating lessons widely in order to inform planning and prevent mistakes being repeated:

'Numerous responders and planners who have been involved in disaster events have written articles reporting lessons learned in these events. A review of this literature, however, shows that many of the problems experienced in planning and responding to disasters seem to be ''learned'' over and over again in disaster after disaster. Although the reasons for this are complex, a significant contributing factor is that disaster planning is only as good as the assumptions on which it is based' (Auf der Heide 2005).

Those tasked with drafting or reviewing emergency plans in the UK should be educated about common myths which might underpin assumptions and plans for disaster response and which can limit the effectiveness of psycho-social and other elements of emergency response. Examples of common myths follow.

Informed Choice vs. Panic

Myth: The most common reaction of people caught up in disasters is to panic. Information about hazards and disasters should not be widely disseminated because people will panic.

Reality: Research generally shows that victims rarely panic; rather people's actions are more likely to be guided by choice and efforts to help those around them who require it, particularly where informed choices are available before or during the event. Auf der Heide (1989) elaborates:

'Contrary to popular belief, research has shown that panic is not a common reaction to disasters (Dynes, 1974:71; Dynes, 1981:16,18; Quarantelli, 1960:68; Quarantelli, 1965:107; Quarantelli, 1972:67; Mileti, 1975:57; Drabek, 1986:136; Wenger, 1975:33; Wenger, 1985a:30). This is not to say that panic never occurs, but that it is rare. Furthermore, if it does occur, three conditions appear to be required (Mileti 1975:58):

- a perception of immediate danger,
- apparently blocked escape routes, and
- a feeling by the victim that he is isolated.

Finally, if panic occurs, it is not widespread or contagious. It is most always highly localized, with few participants, and of short duration (Quarantelli1960:72).' Auf der Heide gives various historical

examples to evidence this lack of panic which is also borne out by testimony of those involved in more recent disasters.

Auf der Heide concludes his analysis with a reminder of key principles for planners, asking whether those responsible for issuing warnings to the public understand that widespread panic is not a common problem in disasters, but that convincing people to evacuate is. The more information about what to do in an emergency is available, the more likely it is that people will feel empowered to act in an informed, responsive and responsible manner. This has been such a consistent theme in the research literature that the recommendations below of Dynes, Quarantelli and Kreps (1972:31), foremost researchers in this field, remains as relevant today as ever:-

'Information about dangers should be disseminated and not withheld because of a fear that people will panic' (Dynes, Quarantelli and Kreps 1972:31).

Victims as First Responders

Myth: Victims are likely to be hapless and powerless to help themselves and others caught up in the impact zone of a disaster. Chaos and disorder will reign until the emergency services arrive to deal with the emergency.

Reality: Disaster accounts highlight that while some people may report feeling powerless, helpless and numb and may appear passive - dazed, frozen or stunned - others will report and demonstrate action-oriented and orderly behaviour focused on helping themselves and others around them. Experience shows that many victims are in fact the first responders at a disaster site, before the emergency services and other help arrives. The disaster literature consistently shows that that initial search and rescue activity, casualty care and restoration of services are accomplished by the victims themselves, with the assistance of people and organisations from the immediate filter area.

Thus accounts of survivors from events such as rail disasters, terrorist attacks and natural disasters reflect how people often join in search/rescue activities, give first aid, seek help and call home/others. Some report that far from feeling frozen they are galvanised into adaptive action, feeling on a high or on auto-pilot. Research has long borne out this active form of response and the implications for responders:

'It should be assumed that persons in disaster-impacted areas actively respond to the emergency and will not wait for community officials to tell them what to do' (Dynes, Quarantelli and Kreps 1972:32).

Despite the evidence now discussed in relation to the adaptive and responsible responses to disaster, historically researchers and practitioners have held different conceptions and expectations of victims. In 1956 Wallace defined the 'disaster syndrome' which was reported by various writers of the time as having the following qualities:

'…a psychologically determined defensive reaction pattern consisting of these stages: (1) people appear dazed, stunned, apathetic, passive, immobile or aimlessly puttering around; (2) extreme suggestibility, altruism, gratitude for help, personal loss minimised, concern for family and community; (3) euphoric identification with the damaged community, enthusiastic participation in repair and rehabilitation; and (4) euphoria wears off and 'normal' ambivalent attitudes return (full course of the syndrome might take several weeks)' (Drabek 1986:147).

Drabek explains that later accounts of disaster response qualified the extent to which these types of 'zombie states' reported were actually evidenced and refers to the various factors that influence the

nature and extent of stress reactions after disaster (these are discussed later). Based on his review of disaster research, therefore, Drabek reinforces the point that some disaster victims react in an active manner, not passively as implied in the dependency image. They may not wait around for offers of aid by organisations, but, in some cases, will demonstrate controlled and rational behaviour:

'…rational here meaning that it is guided by existent roles. But not everyone behaves identically – the invisible strings of socialisation continue to guide groups of people differently, just as in everyday life' (Drabek 1986: 133).

Writing after the Aberfan disaster, Miller (1974) reflects the thinking of the day which focused on the disaster syndrome. She refers to the concept and illustrates it with examples of dazed, docile behaviour and a lack of emotional reaction within Aberfan at the time of the disaster and after (1974:86-7). A re-reading of accounts from this event, however, shows that there was also evidence there of active and rationally focused behaviour both in the immediate post-impact phases and after (for example the formation of orderly 'bucket chains' by families helping in the rescue and recovery effort).

Drabek calls for more comparative research to illustrate variations in how behavioural responses might reflect continuity in underlying values and the emergence of normative guidelines as adaptations to specific aspects of events (Drabek 1986:150-1). They key point here is that we must be wary of generalising in planning and response about the capacity and capabilities of victims involved in events and should perhaps revisit our assumptions about 'victims' and helpers. The practical implication of such research findings is that efforts should focus on engaging victims as first responders by involving them in pre-incident education and awareness raising initiatives, as well as building on their capabilities, resilience and qualities of self-sufficiency in the face of disaster.

Resilience and Organisation within Communities

Myth - In the days and weeks following disaster communities are unable and unwilling to help themselves and will need to rely solely on external help.

Reality - Sociological studies have demonstrated both the resilience of people and their willingness to engage in active, community based activities in the aftermath of events. Furthermore in general terms conflict, including that between organisations, appears to be reduced somewhat, even if only temporarily. This kind of finding has a long pedigree, having been found to be common over thirty years ago and in studies ever since. The following classic observation of Dynes, one of the founding fathers of sociological disaster research, is typical and reflects the findings of more recent reviews:

'…disasters create unity rather than disorganisation. The consequence of a disaster event on a locality is in the direction of the creation of community, not its disorganisation, because during the emergency period a consensus of opinion on the priority of values within a community emerges; a set of norms which encourages and reinforces community members to act in an altruistic fashion develops; also a disaster minimises conflict which may have divided the community prior to the disaster event' (Dynes 1970a:84).

Some years later, Drabek's systematic review of findings of key research findings from nearly 1000 published studies of human responses to disasters similarly found that 'following a community disaster, a majority of families will express general support for and a willingness to participate in emergency procedures to unify and protect families and their possessions' (1986:28). He does qualify this however by commenting that the extent to which stated commitments might last remains unknown, as does the behavioural dimension: ' To express a willingness to participate is

one thing, to act or commit resources quite another' (1986:28). On the whole, however, other and more recent analyses support these consistent findings about resilience and community solidarity post-disaster (Gordon (2004a), Tierney (2001)).

References to the 'honeymoon period' and 'therapeutic communities' (Raphael 2000) that emerge post-impact highlight the value of planners recognising the beneficial effects of such solidarity for community-based support. During this 'honeymoon period', active support typically comes both from within and outside of stricken communities, with responders including those not just those formally mandated and identified in pre-emergency plans. Spontaneous and altruistic commitment to helping emerges as a strong theme underpinning activity in the aftermath of disaster.

'The desire to help is intense and defines one of the most significant dimensions of the overall response' (Drabek 1986:143). This massive helping response is extensively documented in research, even though the nature of helping behaviour may vary across events and societies. Drawing together themes from a number of studies Drabek states:-

'The 'helpers'' response to a disaster is characterised by solidarity. This is expressed by the emergence of core values, the strengthening of pre-existing and emergent networks, and the actions of counter-disaster, voluntary and other organisations. The emergence of core values is observed in the consensus on priorities, altruistic behaviour and the disappearance of any barriers between individuals' (1986:143).

Personal accounts by those involved in responding to UK events in the 1980s bear out this pattern, including the very positive commitment and solidarity of staff responding to major incidents:

'All those staff and voluntary helpers who took part in the early rescue procedures and later hospital management were totally committed to helping and giving their time and skills freely' (Wallace et al on the Kegworth response (1994:9)).

'I also remember a tremendous feeling of team spirit and being cared for by our senior management…Our then chairwoman of the Social Work Committee baked us cakes, while our deputy director arrived with fish suppers. Overall the main support was knowing that whatever resources were needed, they were there' (Bone (1996:27) on the response to the Piper Alpha Disaster).

While acknowledging that disaster-struck communities are resilient and adaptive, it is also important to note that the honeymoon period is usually temporary and may be short-lived and that organisational and personal conflicts often feature and may even impede decision-making and service provision in the aftermath of events. As the case studies discussed later in this report (Part IV) highlight, dealing with disaster is a political and bureaucratic exercise, not least given the involvement of a vast range of agencies and organisations which may be vying for ownership and control. Myers (1994) notes that specialized response and recovery agencies may move into action and exert a significant influence on the postdisaster environment. She observes that resources, structures and individuals change as specialized response groups finish their jobs and move on and as new, grass-roots groups spring up. Myers thus highlights the importance of psycho-social and other responders being able to understand and function effectively in such complex and fluid political and bureaucratic networks.

Involving the Community in Emergency Planning and Management

The implication of this research for those developing emergency plans is that efforts should include recognising the resilience within communities. Emergency planning departments might benefit

from extending their remit to further informing the public about their work and further exploring and evaluating the potential benefits of outreach programmes educating the public about personal, family and community emergency response. In considering the implications of large scale disasters, we might learn from the approach of the US whose experiences and expectations, (albeit of much larger scale natural disasters where first responders may not be immediately available) has led them to consider more proactively the role and preparedness of citizens in emergency planning and response. There the government's 'Ready' Campaign is based on the assumption that following a major disaster, first responders who provide fire and medical services may not be able to meet the demand for these services. Factors such as the number of victims, communication failures and road blockages may prevent people from accessing emergency services they have come to expect at a moment's notice. People will therefore have to rely on each other in order to meet their immediate life saving and life sustaining needs (http://www.ready.gov/).

In the US this kind of approach is backed up by initiatives driven by organisations like the Department for Homeland Security and the American Red Cross who promote and support personal, family and workplace disaster planning. The Department of Homeland Security's Ready Campaign includes guidance information for direct dissemination to the general public based on the most reliable hazard awareness and emergency education information. It seeks to help citizens be better prepared for even unlikely emergency scenarios with information on how the public can be ready in case of a national emergency - including a possible terrorism attack involving biological, chemical, or radiological weapons. Community based emergency planning programmes such as the Community Emergency Response Team (CERT) programme and Citizen Corps actively promote community based emergency awareness, planning and response (http://www.fema.gov/areyouready/preface.shtm).

Part of the impetus for such programmes is the ongoing nature of threat associated with large scale natural disasters and the continual vulnerability of certain communities to such hazards. The nature of the preparedness and planning guidelines reflect this and might not seem at first to be so directly appropriate in the UK. However the philosophy enhancing community resilience through self-help is certainly relevant and has been to some extent recognised in the government's dissemination of guidelines to the public on preparing for emergencies (www.pfe.gov.uk/index.shtm). Given that in the US the Department for Homeland Security has extended the philosophy of self-help through its programmes in the light of more recently perceived threats such as terrorism, such activity is of clear relevance to the UK currently. A further advantage of promoting self-help and engaging local people in emergency planning activities ahead of disaster is that it might help address the difficulties associated with spontaneous volunteers who commonly emerge post-disaster but who have not been adequately screened and prepared to respond before disaster. As research by Lowe and Fothergill (2004) detailed below highlights, there are also therapeutic benefits to local people being involved in community-based response activities which might be further enhanced through such initiatives.

Myth: In planning for a community disaster we should expect that emergency responders will not be available due to their attending to families' needs or other forms of role conflict or role abandonment.

Reality: In response to this myth, research and disaster experience shows that role conflict experienced by organisational personnel does not precipitate role abandonment; rather the tendency is to remain on the job, often for too long (Drabek 1986). The work of researchers such as Quarantelli (1982:10) has highlighted that organisational planners should recognise that what many fear rarely occurs; that is, upon learning of a disaster, personnel do not flock to their homes. If they reside in the impact area, however, efforts may be made to ascertain family members' safety. Thus emergency plans should take account of this and include arrangements for keeping responders

apprised of the welfare of their families and providing cover where necessary. Based on more recent experience Waddle (2006) emphasises the importance of conducting further research and planning to address this significant element of disaster management.

Convergence in Disasters: Therapeutic Voluntarism

It is important for planners to prepare for and expect various forms of convergence in the aftermath of disasters, a consistent pattern identified in disasters. Early studies in the 1950s by the National Opinion Research Centre in the US documented this response pattern; since that time it has been observed in numerous other countries (Drabek 1986:174). Convergence takes two forms: external convergence (moving to the disaster area) and internal convergence (moving to specific sites within the disaster area) (Fritz and Mathewson 1957; Lowe and Fothergill 2004).

Forms of convergence which have been identified include:-

- *Personnel* – (in a classic study Fritz and Mathewson categorised these under sub-types, e.g. the returnees, the anxious, the helpers (including rescue volunteers), the curious and the exploiters (Fritz and Mathewson 1957:29).

- *Informational* – media representatives, messages.

- *Material* – money, resources, gifts (including 'diplomatic' gifts which may be politically sensitive and thus diplomatically impossible to reject or return), flowers, toys etc; often these might be insensitive or inappropriate.

In terms of personnel as convergers, disaster researchers have over the years observed and documented the important role played by volunteer citizens and organisations in disaster aftermath. In community wide disasters they have seen this as part of the 'therapeutic community response' (O'Brien and Mileti 1992:87) in which disaster victims help each other (Lowe and Fothergill 2004:295). Mileti (1999) highlights how volunteer behaviour at the time of a disaster impact, as well as during the post-emergency period, may emerge spontaneously or be institutionalised as part of an organisation such as the Red Cross.

Such convergence can be helpful but also problematic for those responding in the aftermath of events, particularly where voluntarism is 'spontaneous', i.e. people contributing on impulse after an event rather than their contribution being pre-arranged. Lowe and Fothergill (2004) highlight the problems associated with the mass convergence of personnel spontaneously volunteering with the American Red Cross following the September 11 attacks. An initial 'vacuum of authority' from official responders in first 72 hours was followed by a 'mass assault', consistent with socially integrative responses referred to above and typical in natural disasters. Thousands of volunteers from around the country continued to want to help. Indeed, so many individuals wanted to be helpful that service organisations and official agencies had trouble sending them home when they were no longer needed. 'By 2 1/2 weeks after the disaster, the Red Cross had received approximately 22,000 offers of assistance and had processed 15,570 volunteers' (Lowe and Fothergill (2004: 294).

Engaging Volunteers as a Community Resource

Studies such as these are important for emergency planners considering humanitarian assistance. They help us to understand both forms of convergence and their practical challenges. They also illustrate the motivation and psycho-social benefits for spontaneous volunteers (who are clearly impacted on as part of the ripple effect) as well as the broader community they may be assisting. By

discussing their motivation through interviews with volunteers Lowe and Fothergill found that people engaged in helping behaviour both because of compelling altruistic needs to serve members of their commty and compelling personal needs to serve themselves. It functioned to relieve their pain and suffering and to make the situation positive: 'Heightened feelings of victimisation played a strong role in the decisions to converge on the disaster scene and take part' (2004:307-8). The pay off was a form of self-help and heightened self worth: positive experiences of agency through voluntarism 'helped heal the victimisation by transforming feelings of helplessness to feelings of efficacy' (2004:308).

Other examples of community volunteering in the aftermath of disaster have illustrated this potential role of participation in meeting the psychological and cultural needs of individuals and communities impacted by events. In Israel communities have faced the daily prospect of suicide bombing for many years. Eshel (2003:1) writes of how the psychological ramifications of rapidly recurring terrorist attacks have reached enormous proportions for civilians, especially the first-responding rescue teams dealing with the aftermath of suicide attacks. One of the most harrowing duties falls to the members of the volunteer organization Chesed Shel Emet ("True Mercy"), also known officially as ZAKA ("Identification of Victims of Disaster"). These ultra-orthodox Jews contribute to the disaster management process by carefully tending to the ancient Jewish ritual of giving the dead a proper burial. In this sense they regard their role as a mission, fulfilling an obligation and providing comfort to families. While these deployments are undoubtedly stressful and do take their toll on volunteers responding frequently to macabre scenes, the wish and vocation to participate in the aftermath of disasters highlights how voluntarism can be enhanced by a strong sense of purpose and value.

Lowe and Fothergill (2004: 309-10) draw out the implications of such studies of voluntarism for emergency planners, stating that practitioners should understand the need to volunteer and positive impacts of voluntarism. They should consider the intrinsic benefits to helpers and reframe their thinking about spontaneous volunteers – from *problem* to relief effort to *community resource* – and should train members of the community as a resource rather than victim:

'We suggest an effective way to serve those indirectly affected is to design emergency response plans in anticipation of the 'need to do something' (2004:310).

Further work on the precise mechanisms for integrating volunteers is being undertaken by organisations such as the Red Cross, including a joint project being undertaken by the British, Austrian, Estonian and French Red Crosses focussing on involving citizens in civil protection (further details are available from Martin Annis at the British Red Cross: mannis@redcross.org.uk).

Key Points

- Emergency managers should be made aware of common myths about human behaviour in disasters and address their plans accordingly.
- The more information is available about what to do in an emergency the more likely it is that people will feel empowered to act in an informed, responsive and responsible manner.
- Wrongful assumptions about victims and helpers and their capabilities, resilience and qualities of self-sufficiency should be addressed in emergency planning, training and education.
- Planners should expect and plan for convergence after disasters, including promoting the potential benefits of training and engaging volunteers.

Further Reading

Auf der Heide E (2005) The Importance of Evidence-Based Disaster Planning (Article in Press, available at http://www.semp.us/pdf/AufderHeide-Evid-BasedDisasterPlanning.pdf)

Auf der Heide E (1989) Disaster Response: Principles of Preparation and Coordination' Eric Auf der Heide, Atlanta

Lowe S & Fothergill A (2004) 'A Need to Help: Emergent Volunteer Behaviour after September 11' in Beyond September 11th: An Account of Post-Disaster Research (2004) Special Publication No. 39, joint publication by Public Entity Risk Institute, Institute for Civil Infrastructure Systems, and the Natural Hazards Centre at the University of Colorado at Boulder

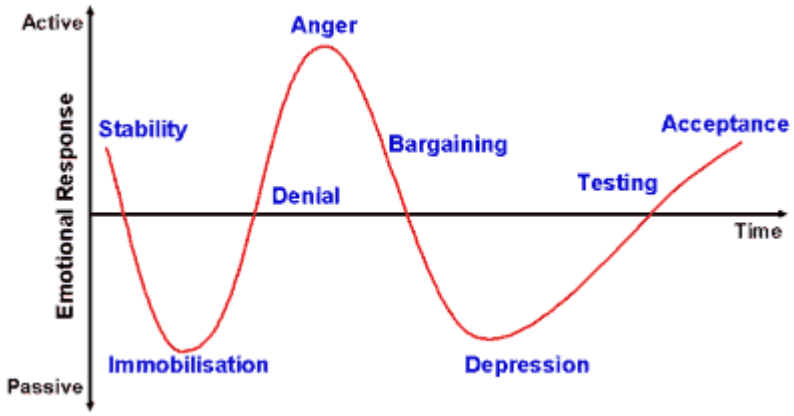
Part II: Emotional Impacts and Reactions to Disasters

In this section of the review evidence about the psychological and social reactions of those most directly affected by disaster is outlined in more detail. Bearing in mind the ripple effects discussed earlier and the acknowledgement that degrees of vulnerability and resilience will vary in both individuals and communities, a general overview is provided here of the common reactions of people to disasters experienced as sudden, unexpected and traumatic events.

Hodgkinson and Stewart make the point that we should remember that disaster survivors are ordinary people: 'the only thing that distinguishes them...is that they happened to be in the wrong place at the wrong time. Their very ordinariness presents helpers with new challenges in terms of the organisation of services, and with an old problem, perhaps the central problem of existence - loss' (1996:1).

Phases of Loss, Trauma and Disaster

Disaster impacts are unlikely to be sufficiently understood without an appreciation of the effects of loss. Experts on loss and bereavement have long discussed the impact of loss in terms of phases or stages of reactions. In her classic study of death and dying Kubler Ross (1969) described the emotional reactions associated with loss through terminal illness which are also relevant to the multiple forms of loss experienced in disasters. The link between loss and phases is illustrated below:



Depiction of Kubler-Ross' Grief Cycle
(http://changingminds.org/disciplines/change_management/kubler_ross/kubler_ross.htm)

Reactions to trauma have also been described in terms of phases or stages of impact and recovery. The phases of traumatic stress reactions in a disaster, for example, are outlined by the National Centre for Post Traumatic Stress Disorder (NCPTSD 2005a) in a fact sheet outlining categories of reactions from the impact phases through the immediate post disaster phase ('recoil and rescue') to the recovery phase. As with grief work, some also talk about trauma recovery in terms of tasks or 'working through', while acknowledging that the processes of recovery involve a time of disruption, disorientation and restlessness. 'Successful recovery from trauma will … involve the building of a new model of life – a model which includes the experience of the trauma and yet allows you to carry on and re-gain control over your life' (Herbert 1995:22).

It is therefore fitting that in developing the discipline of disaster management, events have been conceptualised in terms of phases or stages. Tierney (1989), for example, outlines a typical framework for the phases of disasters and their management:

- Mitigation
- Preparedness
- Response
- Recovery

With reference to the psych-social dimensions of such an approach, Gibson (1994: 138) describes the phases of disaster in terms of a 'time continuum of psychological rehabilitation', ranging from pre crisis to the shock of the crisis stage and after, through to the processes of acknowledgement and adaptation in the medium and longer term post crisis stages.

While these concepts of phases or stages may be helpful in outlining some of the typical kinds of reactions to events and in considering the appropriateness and timing of particular psycho-social interventions, they should be considered only as a general guide. Drabek acknowledges that the rigid application of rational categories and boundaries might not be appropriate and suggests that the transition from short term to longer term restoration and recovery involves a 'fuzzy temporal split' (1986:201).

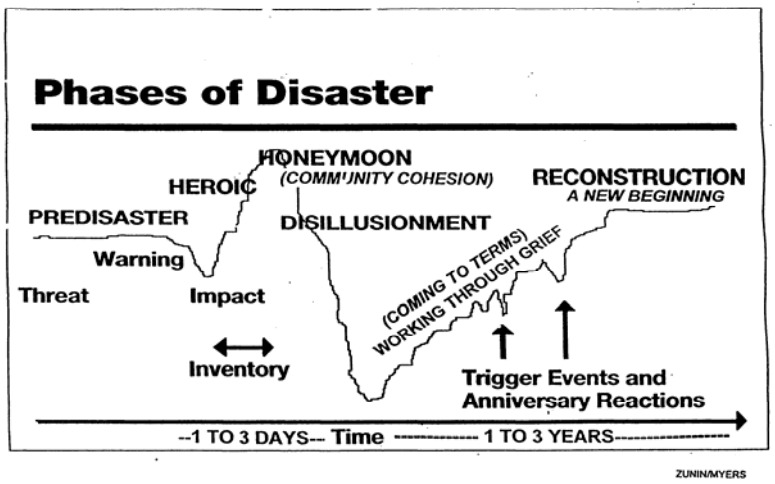
Other writers and practitioners specialising in loss and bereavement agree and point out that these stages are neither exclusive nor necessarily experienced in a sequential way. Erica Brown (1999:5), for example, stresses that the process of grief does not progress through straightforward clearly defined stages beginning with the discovery of the loss and ending with the return to normal life. Here the metaphor of grief coming and going like waves in the ocean is useful. This is particularly so in the case of disasters where many complex, longer term processes associated with death (such as ambiguous loss which we discuss later) and disaster management (including delayed body recovery and identification processes as well as lengthy legal investigations), may well impact on the emotional cycle of those bereaved and/or survivors over the following years. The findings of NOVA (1985) on the impact of criminal justice processes for families of homicide victims are relevant to many disaster victims. They highlight the interruptions to recovery imposed by the experience of the criminal justice system, adding that the criminal justice process is at least as likely to compound the survivors' distress as to reduce it.

Gibson highlights why platitudes about returning to normal and about time healing can be unhelpful given the political and legal aftermath of incidents:

'A late crisis time, such as giving evidence at an inquiry, can make the person feel that any progress they have made has been destroyed and that they are forced back to a more painful and earlier reaction' (Gibson 1994:137).

Those directly involved in disasters thus highlight the importance of exercising caution and sensitivity in applying a simplistic time-lined approach to understanding reactions; they often talk about the fact that life will never be quite the same again, adding that people do not return to the same pre-disaster state as before. A helpful term here is the notion of finding a 'new normal' as part of 'recovery'.

With this in mind, a model depicting the common phases of disaster experienced by communities in disasters is outlined below. This model, developed by Zunin & Myers (1992) on the basis of disaster research and experience, is extensively used by organisations such as the American Red Cross in planning and training for disaster response.



Beyond Stereotyping Victims

As discussed earlier, there are likely to be many varied reactions to disasters based on factors such as one's personal history and personality, specific experience in an event and opportunities for support. Research and experience in the 1980s greatly increased the understanding amongst responders in the UK and internationally of the psychological effects of disasters and the importance of outreach support. Some of this understanding has been effectively incorporated in planning, training and response but, as well as the need for more consistency in levels of organisational resilience, more awareness raising and education about the basic needs and care of people affected by incidents seems necessary in the UK. The meaning and application of a non-judgemental approach should be included in training and education and stereotypes combated.

Thus, for example, while it is important to move beyond conceptualising all victims as homogenous groups, it is not unusual to hear over-generalised or misleading assumptions being adopted or communicated about '*the* bereaved' or '*the* survivors' following an event. It may even be implied that 'good' or 'easy' victims are those who suffer silently or do not cause aggravation to those in authority or those charged with addressing their concerns. The media can perpetuate the view that victims who demonstrate qualities of forgiveness or magnanimous charity to others in spite of their suffering are more desirable and less problematic or troublesome than those who are demonstrably angry and/or outspoken. It is very important that those responsible for psycho-social care and support after disasters are educated about the presence and inappropriateness of such stereotyping and are able to understand that labelling and discussing people in these terms, either publicly or in informal conversations, is inappropriate.

In seeking to be responsive to the needs of people, it is also perhaps easier to assume that the experiences, reactions and feelings of those most vocal or most active individuals (for example those who present themselves to the authorities or are particularly high profile in the media after an event) are representative of all others. Given the politically sensitive environment after an incident, it may be tempting for those in authority to adopt knee jerk reactions in order to be seen to be responding to the humanitarian concerns of victims. In the long run this may not be helpful if responsiveness is later seen as short-lived or partial. This highlights the importance of adopting approaches that are strategic, mindful of the range of reactions and interests of all those affected and cognizant of the longer term impacts of disasters.

With this in mind the following material discusses some of the very many and varied reactions experienced after disasters, while stressing that some or all may apply to particular individuals caught up in the ripple effect.

Dimensions of Loss in Disaster

Loss is an inescapable consequence of disaster (Gibson (1994:133)). Following on the phases of loss referred to above, in the UK experiences of loss tend not only to have multiple dimensions, but are usually unprepared for, sudden and traumatic. The elements of loss in disasters are not always easy to quantify but are extensive and powerful nonetheless. They may include loss of life, health, income, occupation, property, personal life plans, identity, security, a sense of time and order - past, present and future, faith and meaning of life. Even in addressing the more tangible physical elements of loss, such as in relation to property, it is important that emergency planners and responders acknowledge the emotional meaning of loss and the symbolic significance of the possibility and nature of recovery (Eyre and Payne 2006).

Hodgkinson and Stewart describe the powerful effects of such losses and linked emotions:

‘Above all, in psychological terms, they lose faith - not religious faith, but faith in the fact that life has a certain consistency and meaning. The fabric of everyday existence is torn away to reveal danger and risk. For the survivor, the encounter inevitably involves a corruption of innocence. Once something of this nature has happened to a person, it is every difficult for them to believe that life can ever be the same again; that they can let their children walk across the street; or that they can safely go to bed at night. It is also difficult for them to avoid thinking not only that something else terrible might happen, but that in some way they have been singled out, or even that ‘if such a terrible thing can have happened to me then I must have done something to deserve it’(1996: 1-2).

Some of the common feelings associated with loss are outlined below:-

<u>Common Feelings Associated with Loss</u>

- Shock
- Searching
- Disbelief
- Anger
- Hate
- Ambivalence
- Isolation
- Frustration
- Despair
- Hopelessness

- Bitterness
- Guilt
- Fear
- Anxiety
- Loneliness
- Acceptance

Carrie Freitag (2003), in reflecting on her own personal experience of bereavement through sudden traumatic death, links episodes of loss explaining that 'we do not really experience just one loss at a time because one loss triggers the feelings abut past losses, especially if there are unresolved feelings and issues. This is true whether we are talking about deaths, relationships that have ended, or other life changes that involve saying goodbye to someone or something. They all involve loss and grieving' (2003:28).

In response to this bereavement specialists such as Worden (1991) describe grief work and the 'tasks of mourning' that are necessary after loss. These involve:-

- Accepting the reality of the loss
- Experiencing the pain of grief
- Adjusting to a new environment
- Investing in new relationships

These periods of adjustment and adaptation are necessary for normal functions to take place (Brown 1999:1).

In disasters, however, there are dimensions of the nature, scale and forms of loss that may compound the impact and experiences of grief and mourning. Death in disaster may involve three kinds of untimely death (Weisman (1973)) namely premature death (for example involving children), sudden unexpected death, and calamitous death, 'not only unpredicted, but violent, destructive, demeaning and even degrading' (Hodgkinson and Stewart 1996:32). Multiple loss through the death of more than one member of a family or community can also be a feature of disasters with devastating consequences: 'Those who are multiply bereaved are most depleted. They are coping with both the cumulative effects of several losses and the virtual eradication of social support networks, not only in terms of physical absence, but in terms of other relatives unavailable owing to their own grief. The bereaved person is thrown into a state of overload' (Hodgkinson and Stewart 1996:40).

Ambiguous loss

Death and loss through disaster can thus make mourning processes potentially more complex. The emotional processes of adjustment and adaptation might not be as straightforward as death in other circumstances and can be complicated by the nature of death and its management in the hours, days and weeks following an incident. In some cases confirmation of death and the mourning process can be temporarily, or in some cases even permanently, impossible; rather a state of ongoing 'ambiguous loss' can apply. This concept of ambiguous loss was introduced and developed by Pauline Boss (2000) who first learned about the power of ambiguity in complicating loss when interviewing families of soldiers missing in action in Vietnam and Cambodia in 1974. She described the deep pain of those without certain confirmation of the status of loved ones and the ambiguity of waiting for news and wondering whether they were dead or alive.

Ambiguous loss persists where loved ones are perceived as *physically absent* but remain *psychologically present* with the effect that, in contrast to more ordinary, clear cut loss, the

bereaved are more prone to depression, anxiety and relationship conflicts as a *normal* reaction. This is because the loss is confusing and uncertain; people are prevented from adjusting to the loss by reorganising the roles and rules of their relationship with the loved one. The lack of official verification, such as a death certificate or body to view, adds to this uncertainty and the social ambiguity of the status of those left behind. The absence of symbolic rituals such as a funeral compounds this ambiguity and the difficulty of being able to express its effects.

Boss comments: 'In the case of ambiguous loss, melancholia or complicated grieving, can be a *normal* (italics added) reaction to a complicated situation …the inability to resolve such ambiguous losses is due to the outside situation not to internal personality defects. And the outside force that freezes the grief is the uncertainty and ambiguity of the loss' (2000:10).

She continues:

'Just as ambiguity complicates loss, it complicates the mourning process. People can't start grieving because the situation is indeterminate. It feels like a loss but it is not really one. The confusion freezes the grieving process. People plummet from hope to hopelessness and back again. Depression, anxiety and somatic illnesses often set in…' (2000:11).

Ambiguous loss can be particularly relevant in disasters whether the period of ambiguity lasts for hours or days or longer (for example between hearing first news of an incident and having positive confirmation of a loved one's death). Indeed the drive for information and confirmation of the welfare of loved ones is very powerful in the immediate aftermath of events and explains the huge influx of calls to Casualty Bureaux and attempts at gaining news and verification from other sources. In this sense searching is both an emotional and physical reaction and responders and those offering immediate psycho-social support should both expect demands for, and facilitate access to, information where available. The significance of ambiguous loss and the importance of information should be clearly understood by responders and those providing humanitarian assistance.

Searching for Information and Answers

Observing his own and others' reactions to Hurricane Katrina, Scurfield (2006) refers to the period of activity-focused responses after disaster as a 'tunnel vision phase' which overlaps with the 'heroic' and 'honeymoon' phases referred to above. Searching for information, loved ones, property etc is one example of such reactions and was widely in evidence after events such as the September 11 attacks, the Asian Tsunami and the London bombings. Friends and family members trawled hospitals, temporary mortuaries and reception centres, posting their own messages and photos and asking for news of missing people. When official channels fail to provide answers (for example through lines being blocked or answers not being available), individuals are likely to circumvent official channels in their quest. The growth of websites and the role of news channels (such as the BBC disseminating details of missing people after the tsunami), demonstrate that it is impossible for the authorities to control the flow and validity of information and reminds us that parallel sets of response driven by the bereaved and survivors are a significant form of disaster management which should be taken account of in understanding the whole picture of needs and activities in the aftermath.

In exceptional but significant cases of recent disasters, families have been left in the ambiguous state of having no positive identification or body following disaster for many months or years. On the first anniversary after the Asian Tsunami of 2004, between 750 and 800 bodies had still not been formally identified. Three years after the September 11 attacks relatives of 1,169 of the 3,000 who died had not received any remains (Laurence 2004). Meanwhile, although all victims of the July 7 bombings in London were formally recovered and identified in a much shorter time frame

than this, anecdotal information suggests that the period of time between the days of the attacks and the positive identification and opportunities to view bodies caused great upset and anger for family members.

Planners and responders thus need to be aware of the significance of these reactions over periods of time after an incident and of the importance of addressing family's needs as quickly and expeditiously as possible. Disaster Action stresses that speedy identification of bodies, for example, is 'an issue of paramount importance to families' and argues that professionals such as the Identification Commission must consider speed as well as accuracy: 'We would argue that it is inhumane to prolong the waiting period for those whose family members' bodies are capable of being identified relatively quickly' (Disaster Action 2005b).

The importance of timely, detailed and accurate information helps to explain the frustration and anger often felt by families waiting for information about loved ones' involvement, likely death and positive identification. These sentiments were expressed to Tessa Jowell by families bereaved by the July 7 bombings who also expressed anger at the lack of details available to them about exactly how their loved ones died/the exact time of death (DCMS 2006). The need for answers to these questions must be understood within the context of sudden, unexpected loss and bereavement, for unless and until an account of how, whey and where loved ones died is available, many are unable to start the processes of mourning. Elsewhere I have described disasters as involving *complicated deaths* in this respect because it is not always straightforward to establish the nature, cause and moment of death:

'This is important because these are questions which survivors want answers to and which can cause added anxiety in the personal, political and legal aftermath of disaster. Survivors are often left with inconsistent, incomplete or conflicting accounts of how, when and where their loved ones died. Consequently in situations of mass tragic death the increased need to blame someone, as a feature of grief through sudden death (Worden 1991:99), often becomes legitimately focused on the responding authorities and the way in which they conduct their affairs' (Eyre 1998).

'Double Loss': The Impact of Disaster on Relationships

The ripple effects of loss following disaster, not just in ambiguous loss, can mean that relationships between family members can suffer. Drabek recognised this as a type of negative impact of disasters meriting further study and commented on how after disasters 'some may respond by turning their anger inward, perhaps others lash out at loved ones' (1986:208). Norris et al (2005) note from their extensive literature review of pychosocial resources in the aftermath of disasters that while most people are most comfortable seeking and receiving help from family members, family members are also a significant source of strain and conflict (2005:4).

Newburn found that considerable strain was placed upon family and personal relationships after Hillsborough: 'There were many that were quite radically changed and some that simply didn't survive. For the bereaved in particular this represented a 'double loss'. Negative or problematic consequences were reported both between partners and between parents and children' (1996a:15).

For survivors too, the effects of being involved in a traumatic event may impact on relationships, particularly where close family and friends are unable to fully understand and identify with their experiences and feelings. Hodgkinson and Stewart (1996:8) report that survivors may become very precious about their experience, discounting those who can never really understand. 'They may set up a group from which 'those who cannot understand' are excluded. This can have the effect of generating a powerful sense of survivor identity which provides a vehicle for anger and action, restoring a sense of control. It gives vent to feelings of having been let down by the very exclusion

of authority and officialdom. At the same time, however, it may freeze the survivors in time, with the sole identity of 'victims'' (Hodgkinson and Stewart1996:8; Lifton 1983).

Survivors' experiences and reactions might also impact on relationships with partners:

'Where one partner is a survivor of an event the other did not experience, the survivor often feels that the partner cannot understand because they were not there, and comfort may only be found in the company of other survivors. He or she may never share all that happened, leaving the partner feeling excluded or resentful. The partner in turn may compound things by remaking 'I can't understand what all the fuss is, you weren't hurt or anything, were you?' (Hodgkinson and Stewart 1996:16).

These examples illustrate both why support groups can be meaningful and also why it is important for other community support networks to be available to the bereaved and survivors. As well as natural networks, help for those outside of family and friends may be especially helpful, 'because the person most directly affected can still feel alone and overwhelmed by his or her emotions, when friends or relatives may be ready to get back to normal activity' (Gibson 1994:141). Newburn stresses making these networks of support available early on: 'Intervention at the point of crisis may avert the longer-term consequences of broken relationships, and reduce the chances that those who are vulnerable will get into negative work and behaviour patterns' (Newburn 1996a:16).

Trauma and Disasters

It is important for anyone responding to those affected by major incidents or disasters to understand the nature and effects of trauma. Here we discuss the links between disasters as traumatic events and common effects of them, including appropriate interventions for differing types of post-traumatic stress reactions.

Traumatic reactions can occur when a person has experienced, witnessed or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others. A person's response may involve intense fear, helplessness or horror (American Psychiatric Association (1994)). Such events and reactions are not exclusive to disasters but certainly include them, particularly since the events of disasters are often experienced as sudden, unexpected, large scale and involve mass death and/or injury.

Traumatic experiences, including in disasters, are distressing and threatening. They can be so intense as to temporarily disrupt a person's ability to come to terms with them. 'Thinking you might die, seeing others killed or injured, intense fear, abuse or being forced to do things out of your control are all traumatic experiences' (Gordon 2004:1). Guides for survivors of trauma seek to highlight the significant impact of trauma: 'Sudden, traumatic life events can shatter people's lives. They can have a profound effect on the way that people feel about themselves and the nature of the world around them. People can experience utter confusion and often terror about the way they are feeling and behaving after a sudden traumatic event' (Herbert 1995:12).

The Effects of Trauma

It is most helpful for those directly affected by trauma, and those working with or supporting them, to recognise these effects. Gordon describes them in one of a series of leaflets he has produced which have been used following several disasters both in Australia and further afield (2004:1):

'A traumatic experience can temporarily shatter basic assumptions about life or other people such as trust, safety, predictability. The feelings caused may be so intense that unlike normal distress, they do not fade with time, but either continue the same or get worse after a while. People may feel fear

even when it is quite safe. They may be constantly on edge and not respond to normal reassurance or opportunities to relax. Their tiredness may continue on for much longer than seems reasonable. They may have periods of being numb or detached and not wanting contact, followed later by the opposite. They may feel they failed or did the wrong thing at the time (even if this is not true). Usually they remember a combination of very intense fragments of the happenings that does not go away, combined with important gaps that make them feel uncertain about what really happened'.

For the vast majority of people, such normal post traumatic stress reactions are temporary, that is to say most people recover from traumatic experiences, but it usually takes them longer than would be expected for non-traumatic crises. The NCPTSD (2005b) outlines the range of possible reactions to a traumatic situation that are considered within the norm for individuals experiencing traumatic stress:-

Effects of Traumatic Stress in a Disaster Situation (NCPTSD (2005b))

Emotional Effects

- shock
- terror
- irritability
- blame
- anger
- guilt
- grief or sadness
- emotional numbing
- helplessness
- loss of pleasure derived from familiar activities
- difficulty feeling happy
- difficulty experiencing loving feelings

Physical Effects

- fatigue, exhaustion
- insomnia
- cardiovascular strain
- startle response
- hyper-arousal
- increased physical pain
- reduced immune response
- headaches
- gastrointestinal upset
- decreased appetite
- decreased libido
- vulnerability to illness

Cognitive Effects

- impaired concentration
- impaired decision making ability
- memory impairment
- disbelief
- confusion
- nightmares
- decreased self-esteem

Interpersonal Effects

- increased relational conflict
- social withdrawal
- reduced relational intimacy
- alienation
- impaired work performance
- impaired school performance
- decreased satisfaction
- distrust
- externalization of blame
- externalization of vulnerability
- feeling abandoned/rejected
- over protectiveness

While outlining these reactions the NCPTSD also reinforces the importance of normalising them rather than pathologising them:

'It is important to help survivors recognize the normalcy of most stress reactions to disaster. Mild to moderate stress reactions in the emergency and early post-impact phases of disaster are highly prevalent because survivors (and their families, community members and rescue workers) accurately recognize the grave danger in disaster. Although stress reactions may seem 'extreme', and cause distress, they generally do not become chronic problems. Most people recover fully from even moderate stress reactions within 6 to 16 months' (NCPTSD 2005b).

Gordon notes that in the days and weeks following traumatic events many people feel a need to 'get back to normal' and put it out of their minds but adds that although this can often be beneficial in the short term and help recovery from normal crises, 'it often only postpones problems for people who have been through traumas. Sometimes they can maintain things for some time (although those around them often see that all is not well) and eventually something happens that brings it to the surface again. This can happen even months after the event' (Gordon 2005:1).

Recovering from Trauma: What Helps

The important thing about recovery from trauma is to go back over what happened so that the feelings fade and the person can come to terms with the event, realise it is in the past and how they can be safe again. Gordon (2005) states that this has to happen at a time and rate that is comfortable for the individual. Such a situation may not always apply after disaster when persistent media coverage and engagement in processes such as interviews, investigations and other procedures might interrupt or disrupt the ability of survivors to maintain control over their recovery.

As discussed, practical information advising people that their feelings are within the normal range of reactions to abnormal circumstances can be of much benefit in the days and weeks after disaster. As well as allaying fears that sufferers are going mad and providing assurance that with self care and support recovery is possible, details of how to access further help and support are essential. Such information may be portrayed verbally by crisis support workers and also through information leaflets which should be made freely and widely available as part of any disaster response. Many are based on a classic style such though it is important that any leaflet is reworded with specific attention paid to the context and circumstances of the event which it is addressing (by way of example, details of the leaflets used and adapted for the Tsunami Support Network are referred to in Note 2).

Those with direct experience of trauma, as well as professionals, have highlighted how other people are often the most valuable form of support, even though it may be difficult for them to be confident about what to do. 'Uncertainty and the wish to avoid distress can make those close to the affected person keep away from the experience or from them. It is usually best to ask how you can help and to let them know they can talk if they want to' (Gordon 2005:1).

The guidelines issued by the National Institute for Clinical Excellence (NICE) reinforce the importance of basing communication on the needs and preferences of sufferers. This is seen as part of a patient-centred approach such that treatment and care should take into account patients' individual needs and preferences. 'Good communication is essential, supported by evidence-based information, to allow patients to reach informed decisions about their care. Carers and relatives should have the chance to be involved in discussions unless the patient considers it inappropriate' (2005:2).

Members of Disaster Action have reinforced the importance of choice and reflected on the value of meeting others with similar though different experiences after disasters:

'To meet others who have suffered and who grieve, those who experience the devastation and shock, caused by a similar event is a help and lessens the feeling of terrible isolation - why me, why them, if only, etc etc. If there is to be any understanding of such heartbreak it comes from those who have been there too. This is one thing you all share in common; to them you don't have to explain, they know, they are at your point in heartbreak time' (Disaster Action 2005).

This reinforces the findings of Norris et al's (2005) review of social resources found to be critical for protecting disaster victims in the aftermath of disasters. They comment that levels of perceived and received social support, including that fostered by survivors' social networks, are related strongly and consistently to mental health.

Recognising Resilience and Post Traumatic Growth

As well as outlining negative stress reactions and associated risk factors, many trauma specialists also recognise and are starting to research the nature, extent and implications of resilience in disasters. Resilience refers to the ability to adapt to difficult, challenging, stressful or traumatic life experiences and within the context of emergency and disaster management applies to individuals as well as organisations and communities. In discussing the effects of trauma in disasters, the NCPTSD (2005b) states that in fact resilience is probably the most common observation after all disasters and, reinforcing the findings about therapeutic communities discussed earlier, highlights that disaster may also bring a community closer together or reorient an individual to new priorities, goals or values.

This has been referred to as 'posttraumatic growth' by some authors. Tedeschi and Calhoun (2004) for example refer to the kinds of positive changes individuals may experience in their struggles with trauma. These can include 'improved relationships, new possibilities for one's life, a greater appreciation for life, a greater sense of personal strength and spiritual development. There appears to be a basic paradox apprehended by trauma survivors who report these aspects of posttraumatic growth: their losses have produced valuable gains' (2004).

Tedeschi and Calhoun discuss the nature and themes of post traumatic growth and draw out the implications for those clinicians working with trauma survivors and wishing to facilitate post traumatic growth. They highlight that just as the changes that trauma produces are experiential, not merely intellectual (this being what makes them so powerful for many trauma survivors), so it is for posttraumatic growth: 'there is a compelling affective or experiential flavour to it that is important for the clinician to honour'. Tedeschi and Calhoun state that attention to elements of post traumatic growth is compatible with a wide variety of approaches that are currently utilized to help people who are dealing with trauma:-

'Initially, clinicians should address high levels of emotional distress, providing the kind of support that can help make this distress manageable…Allowing a distressed patient to regain the ability to cognitively engage the aftermath of the trauma in a rather deliberate fashion will promote the possibility for posttraumatic growth' (2004).

The work of Tedeschi and Calhoun is included here because it provides an important balance to approaches that might over-emphasise and over-pathologise post-disaster reactions. In this sense it reinforces the key theme of recognising resilience as well as vulnerability in those affected by disasters and the importance of not generalising but being centred on where particular individuals are at in recognising their personal reactions and needs. Tedeschi and Calhoun also include

important caveats in their work noting, for example, that post traumatic growth occurs in the context of suffering and significant psychological struggle, and stressing that a focus on this growth should not come at the expense of empathy for the pain and suffering of trauma survivors. 'For most trauma survivors, posttraumatic growth and distress will coexist, and the growth emerges from the struggle with coping, not from the trauma itself' (2004).

They also emphasise that in no way are they suggesting that trauma is "good". 'We regard life crises, loss and trauma as undesirable, and our wish would be that nobody would have to experience such life events'. Acknowledging that posttraumatic growth is neither universal nor inevitable they state: 'Although a majority of individuals experiencing a wide array of highly challenging life circumstances experience posttraumatic growth, there are also a significant number of people who experience little or no growth in their struggle with trauma. This sort of outcome is quite acceptable-we are not raising the bar on trauma survivors, so that they are to be expected to show posttraumatic growth before being considered recovered' (2004).

Problematic Reactions, including Post-Traumatic Stress Disorder

Though less common than the normal post-traumatic stress reactions discussed above, the NCPTSD (2005b) outlines problematic stress responses which may occur after exposure to disasters and which indicate that an individual will likely need assistance from a medical or mental-health professional. These include:

- Severe dissociation (feeling as if the world is unreal, not feeling connected to one's own body, losing one's sense of identity or taking on a new identity, amnesia)
- Severe intrusive re-experiencing (flashbacks, terrifying screen memories or nightmares, repetitive automatic re-enactment)
- Extreme avoidance (agoraphobic-like social or vocational withdrawal, compulsive avoidance)
- Severe hyper-arousal (panic episodes, terrifying nightmares, difficulty controlling violent impulses, inability to concentrate)
- Debilitating anxiety (ruminative worry, severe phobias, unshakeable obsessions, paralyzing nervousness, fear of losing control/going crazy)
- Severe depression (lack of pleasure in life, feelings of worthlessness, self-blame, dependency, early wakening)
- Problematic substance use (abuse or dependency, self-medication)
- Psychotic symptoms (delusions, hallucinations, bizarre thoughts or images) (NCPTSD 2005b).

The most extreme abnormal reaction is Post Traumatic Stress Disorder (PTSD), a mental health disorder resulting from exposure to an extreme, traumatic stressor. The features and diagnostic criteria for PTSD as defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994) include:

- Exposure to a traumatic stressor
- Re-experiencing symptoms
- Avoidance and numbing symptoms
- Symptoms of increased arousal
- Duration of at least one month
- Significant distress or impairment of functioning

NCPTSD reports that the percentage of those exposed to traumatic stressors who go on to develop Post Traumatic Stress Disorder (PTSD) can vary depending on the nature of the trauma. However

they emphasise the fact that most trauma survivors will be upset for several weeks following an event but will recover to a variable degree without treatment (2005b).

Research into trauma and our understanding of factors influencing vulnerability and resilience has greatly increased in recent years. The latest trauma literature suggests that many factors are related to the increased or decreased risk for PTSD. 'The likelihood of developing PTSD and the severity and chronicity of symptoms experienced is a function of many variables, the most important being exposure to a traumatic event' (NCPTSD 2005b). Furthermore the NCPTSD states that the following types of exposure place survivors at high risk for a range of post disaster problems:

- Exposure to mass destruction or death
- Toxic contamination
- Sudden or violent death of a loved one
- Loss of home or community.

Diagnosing PTSD: A Mixed Blessing?

Hodgkinson and Stewart (1996:18) ask whether having diagnostic frameworks for post traumatic stress reactions, including PTSD, might be a 'mixed blessing' and suggest that while being able to discern between normal and abnormal reactions provides validation for sufferers, the cut offs for diagnosis tend to be arbitrary with the potential for overuse and over-medicalisation. Survivors may also find the act of diagnosis confusing. 'They may be told for therapeutic purposes that their experience are normal reactions to abnormal events, but for the purposes of medico-legal examination a 'disorder' has to be not only identified, but emphasised' (1996:18).

Responding to Trauma: Appropriate Interventions

It is important for emergency planners and those on crisis response teams to keep abnormal reactions and vulnerability to PTSD in perspective in planning and responding to disasters. Planning, training and response should be based on the fact that most normal, common reactions will recede without the need for long term professional treatment. The NCPTSD (2005b) has highlighted the sorts of factors present in the acute-phase recovery environment of a disaster which have been found to aggravate stress reactions. These increase survivors' risk of developing negative outcomes and should therefore be borne in mind by those managing and providing support services. They include:

- Lack of emotional and social support
- Presence of other stressors such as fatigue, cold, hunger, fear, uncertainty, loss, dislocation, and other psychologically stressful experiences
- Difficulties at the scene
- Lack of information about the nature and reasons for the event
- Lack of, or interference with, self-determination and self-management
- Treatment [given] in an authoritarian or impersonal manner
- Lack of follow-up support in the weeks following the exposure

Protective factors that may mitigate negative effects include:

- Social support
- Higher income and education
- Successful mastery of past disasters and traumatic events
- Limitation or reduction of exposure to any of the aggravating factors listed above
- Provision of information about expectations and availability of recovery services

- Care, concern and understanding on the part of the recovery services personnel
- Provision of regular and appropriate information concerning the emergency and reasons for action (NCPTSD 2005b).

Finally, NCPTSD note that community-related mediators that may help alleviate distress are rapid disaster relief and a positive community response that does not single out certain survivors as victims (NCPTSD2005b).

Where long term interventions for treating PTSD do become necessary, appropriate specialist intervention is needed. Successful recovery cannot take place until a way of understanding the traumatic experience has been found. Thus trauma specialists such as Herbert comment on the role of therapy in helping sufferers to talk and work on specific aspects of the trauma. In this way they may learn to 'regain control over their lives and be able to start to see light again, where they experienced mainly darkness before' (Herbert 1995:13).

Treating PTSD: The NICE Guidelines

The National Institute for Clinical Excellence (NICE) has produced guidelines for treating post traumatic stress disorder (PTSD). In terms of early intervention following traumatic incidents, they suggest that brief, single-session interventions (traditionally known as debriefings) which focus on the traumatic incident should not be routine practice when delivering services (NICE (2005)). Rather, where symptoms are mild and have been present for less than four weeks after the trauma, a process of 'watchful waiting' should be considered. For individuals at high risk of developing PTSD following a major disaster, they suggest that consideration should be given (by those responsible for the coordination of disaster plans) to the routine use of a brief screening instrument for PTSD at one month after the disaster.

Where trauma-focused psychologists treatment becomes necessary, NICE recommends that trauma-focused cognitive behavioural therapy should be offered. Such treatments should normally be based on an individual outpatient basis. They also recommend that all people with PTSD should be offered a course of trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR). Again they state that both these treatments should normally be based on an individual outpatient basis. In relation to such longer-term support, NICE states that services should be provided by those counsellors or clinicians who are adequately trained and supervised.

In terms of disaster planning, NICE suggests that plans should contain provision for a fully coordinated psycho-social response. This should include:

- Provision for immediate practical help
- Means to support the role of affected communities in caring for those involved in disaster
- Provision of specialist mental health, evidence-based assessment and treatment services

NICE also states that it should be ensured that all healthcare workers involved in a disaster plan have clear roles and responsibilities agreed in advance.

Grief and Trauma after Disaster: The Need for Specialist Help

Although bereavement may be caused by a traumatic event, it is important to understand that trauma and grief are different entities, 'their effects operating separately, yet overlapping and interacting' (Hodgkinson and Stewart (1996:27)). Reflecting on PTSD following the Tsunami and ongoing Iraq war, psychologist Mark Dombeck (2005) discusses traumatic stress disorders in

relation to grief and what they tell us about how human beings related to overloading, overwhelming events. His article highlights why grief can be interrupted or complex and why specialist treatment is necessary. This is important for planners to take account of in developing support strategies and for anyone providing psycho-social support after emergencies to understand. 'It is not a good idea to force a traumatised person to talk about what they have experienced. However it is a good idea to recommend that they get professional help and perhaps even assist them in accessing that help' (Dombeck 2005).

Dombeck explains this by outlining how traumatic events fall outside the range of usual human experience; they are untypical, evoke sustained terror and involve the acute threat and/or actual death of others. 'These are overpowering events capable of quite literally blowing someone's mind'. In this way trauma can shatter our notion of the world. We have a mental picture or model of the world built up over our lifetime which helps us make sense out of new situations and people. This mental model allows for prediction: we assume a sense of order and control, tending to believe in a just, law-abiding world based on predictability and certain natural laws. However, states Dombeck, traumatic events shatter people's world models - their just-world hypothesis. People exposed to events with the potential to cause trauma lose the foundation upon which beliefs and understandings vital to their well-being rest. Without this foundation, the world becomes a fundamentally more chaotic, capricious and terrifying place, 'and the task of grieving becomes exponentially more difficult' (Dombeck 2005).

Dombeck describes PTSD, the most extreme reaction, as 'basically an overloaded dysfunctional grief process; one so severely overloaded that the normal grief process gets interrupted and hung up. It is a sort of delay of normal 'emotional digestion'' (Dombeck 2005). PTSD impacts on ordinary grief and abilities to mourn:-

'In a normal grief process initial outcry and anger gives way to cycles of denial, disbelief and numbing, and intrusion (of painful loss-related memories), all of which ultimately work their way through to a new adjustment. Though painful, neither the denial nor the intrusion is overwhelming for too long. In contrast, PTSD involves re-experiencing of trauma related memories which never cease to be overwhelming and paralysing. The traumatised person is unable to cope with the intrusive traumatic memories and is pushed towards extreme ways of avoiding them; drugs to dull the pain, prolonged avoidance of intimacy etc. Working through does not occur because working through requires the ability to tolerate what has been lost, and in PTSD that ability to tolerate is precisely what is not possible' (Dombeck 2005).

Reinforcing the recommendations of others, Dombeck stress that in these circumstances specialist help is required by therapists specialising in trauma which involve helping the sufferer break the cycle of avoidance and come to grips with what they have experienced through careful and systematic exposure to trauma memories: 'This is a very delicate process that really is best left to professionals and then only undertaken with a trusted therapist' (Dombeck 2005). Dombeck highlights why it is important that this kind of interventions is best left to professionals rather than, for example, well meaning befrienders:

'This sort of therapy is too delicate a process to try at home…even since efforts could easily backfire and result in negative outcomes…The patient might avoid working with a real therapist in the future, making it harder for them to get the help they need' (Dombeck 2005).

Having said this, he emphasises that, where appropriate (and, it is here suggested, following appropriate training and education on trauma and its effects), it may be possible to assist a sufferer *on their terms*. 'If someone who has been traumatised wants to talk about it with you, and you are strong and caring and respectful enough to listen, that is a whole different thing' (Dombeck 2005).

Overall Dombeck recommends not forcing a traumatised person to talk about what they have experienced but rather recommending professional help and assisting in accessing that help. This is where community support networks, including access to specialist trauma treatment through primary care trusts and other avenues, is most appropriate following disaster.

Key Points

- Concepts of stages or phases of reactions after disaster are helpful, though we should beware of an over-simplistic time-lined approach.
- Discussion about the inappropriateness of stereotyping (for example about *the* bereaved and *the* survivors, or about 'good' or 'difficult' victims) should be included in education and training programmes.
- Disasters may include particular types of loss, such as multiple and ambiguous loss. This highlights the significance of searching activities and the importance of providing timely, detailed and accurate information after disasters.
- Most traumatic stress reactions after disaster are temporary. Information and activities which normalise reactions, protect social resources and signpost further sources of support are fundamental to good psycho-social response.
- In the case of extreme traumatic reactions, such as PTSD, referral to specialist help and treatment is necessary.

Further Reading

Disaster Action (2005) Reflections on Personal Experiences of Disaster (www.disasteraction.org.uk/support/da_guide08.htm)

NCPTSD (2005b) Effects of Traumatic Stress in a Disaster Situation - A National Centre for PTSD Fact Sheet

Tedeschi R and Calhoun L (2004) 'Posttraumatic Growth: A New Perspective on Psychotraumatology' in Psychiatric Times, April 2004, Vol. XXI, Issue 4 (http://www.psychiatrictimes.com/p040458.html)

Dombeck M (2005): Grief Interrupted: PTSD in the time of Tsunami and War (www.mentalhelp.net).

Part III: Meeting People's Needs: Different Types of Provision

In this section we discuss organisational implications and strategies for meeting people's needs and specific support that has been found to be helpful over particular phases of disaster. A brief historical summary precedes a review of the lessons learned from the 1980s and since. This is based

on our increasing understanding of the impacts of events and the need for proactive humanitarian assistance planning and a rights-based approach to outreach support.

Psycho-Social Support after Disasters: Historical Approaches

In the 1960s and 1970s, disasters such as that at Aberfan in 1966 tended to be analysed in terms of grief and bereavement, reflecting understanding of these reactions but less so of trauma; in fact Aberfan predated general recognition of phenomena such as Post Traumatic Stress Disorder. Thus at this time there was little if any forethought and planning for meeting the needs of those affected by major incidents. Indeed the medical authorities at Aberfan did not feel that outside help would be needed after the disaster and stressed that there was considerable suspicion of such experts and even of local psychiatric workers (the Medical Officer of Health had had to withdraw the mental welfare officer because following one incident when a mother had to be admitted to hospital, it was subsequently rumoured that anyone he visited would be taken to a mental hospital (Miller 1974:63)).

Drabek reports how in the 1970s, in societies like the US, the need to expand community disaster plans to include a mental health dimension started to be frequently articulated (1986:39). By the end of the decade elements of an overall 'disaster counselling philosophy' had been identified in several writings that could serve as a general set of guidelines for planners. A key consideration, however, was the importance of acknowledging and supporting individuals' resilience in offering support. Thus Cohen and Ahearn (1980:75-6) discussed underlying principles supporting guidelines that stated that 'crisis counsellors' should assume that victims are potentially capable of handling their own problems after being helped to recognise barriers to solutions. They stressed that support workers should discourage dependence on them while crisis intervention should focus on helping victims to resolve current life problems caused by the disaster and be enabled to talk about the 'here and now'. This theme is reinforced in the latest reviews of findings from across psycho-social disaster research. Norris et al (2005) state 'whether directed toward the community, family or individual, the emphasis for interventions should be on empowerment, meaning they should draw upon and build strengths, capabilities and self-sufficiency'.

Phase-Appropriate Interventions

As our understanding of the nature of need has grown, so has the development of phase-related interventions. Hodgkinson and Stewart (1996) for example have discussed the organisational aspects of psycho-social response during these differing phases, noting that 'organisation during the preparedness phase has a different character to that in the crisis of the response phase. The emotional and political impetus and the resource issues are different, yet the same issues of service organisation and provision remain the same' (1996:72). Myers (1994) also stresses the importance of recognising the phases of recovery and justifies using phase-appropriate outreach methods in relation to mental health based interventions:

'Certain interventions will not work well during the early "heroic" and "honeymoon" phases, when people are generally feeling energetic and optimistic. To ask people to talk about their feelings if they are still denying the implications of their loss is probably ill-timed. A more phase-sensitive approach would be to help them with their immediate, practical concerns. People will likely be more open to talking about their thoughts and feelings a little later in the "disillusionment" phase. Then, much of the protective "numbness" has worn off. People are anxious, sad, tired, irritable, frustrated, and discouraged. A thorough understanding of the phases of disaster, as well as focused

attention to the phase that individual survivors are experiencing, is essential to successful outreach' (1994; chapter 1) .

Myers suggests, as stated earlier, that in thinking through phases we must always bear in mind that the distinction between real time (i.e. immediate, short. medium, long term phases) and the personal timescales of those directly affected may differ and that a phased approach should not lead to prescription or dismissal of certain phases or emotional reactions (for example, it is important that people understand the ongoing anguish, distress and feeling of impotence families often have around inquiries, etc, as time proceeds). Also, as we have seen with recent events, for some people dealing with the disaster only starts many months or even years down the line and so issues around the transition and closing of services need to be carefully considered. It is particularly important that those planning and providing for psycho-social needs and humanitarian assistance understand this and also the importance of using language carefully in relation to decisions around issues and concepts such as 'closure', 'moving on' and returning to 'normality'.

As also discussed earlier, in considering phases of interventions it is important to remember the difference that getting responses right from the very start and in the initial phases can make to the welfare of those affected later on. Joined up strategic planning and operational response is thus critical at all stages of response, including for the pre-impact phases, even though this section of the report focuses on the impact phase onwards.

A Rights-Based Approach

In recent years, there has been a strong move towards considering the needs, interests and wishes of those who are bereaved and/or survivors from disasters in relation to victims' rights. This is increasingly reflected both in legislation and guidance relating to emergency response both in the UK and internationally. Charters and declarations of rights have also extended to include those who have died (National Funeral College 1996) and the transplantation of organ and tissue after death (Council of Europe (2002) and the UK Human Tissue Act (2004) which has as its central theme the issue of obtaining consent from qualifying family members). In relation to disaster management specifically the Sphere Project has since 1997 been promoting minimum standards in disaster response based on fundamental rights-based humanitarian principles (www.sphereproject.org). This includes the principle that those affected by disaster have a right to life with dignity and therefore a right to assistance. Such statements and standards about humanitarian principles are rarely explicitly discussed and stated into UK-based emergency plans but should be included in training and preparation given the transferability and relevance of their recommendations.

Positive developments in relation to communication and liaison with families after disasters have also been driven in part by the recommendations of public inquiries and in response to the negative experiences of families who have drawn on their experience to campaign for change. For example the catalyst for American aviation legislation on family assistance included the appalling experience of family members after the crash of Air Flight 427 (Walsh 1999). Similarly Lord Justice Clarke's inquiry into the Marchioness disaster and the recommendations he made regarding the identification of victims and the treatment of bereaved families after disasters came about only because of the persistence of the survivors and bereaved in campaigning for such an inquiry.

The impetus to improve standards of care and response in the UK has been further increased by the work of Disaster Action, many of whose members witnessed first hand unsatisfactory attitudes and practices in the aftermath of major incidents of different origin in the 1980s (Eyre 1998). In response to these kinds of experiences Lord Clarke (2001) has recommended that after disaster there should be honest and accurate information at every stage, respect for the deceased and bereaved, and a sympathetic and caring approach throughout.

While all those involved in emergency planning and response ought to be made familiar with such works, guidelines and publications referred to here, it is especially important that the principles and recommendations of public inquiries and charters underpin the approach and work of anyone engaged in the psycho-social elements of disaster management and humanitarian assistance. Gibson's writing implies that this should also include all emergency services personnel since they are involved in the psychological management of an individual at the very beginning of the recovery process. 'The way that they talk to victims or organise the rescue procedures can influence the way in which a victim will react to future offers of help. Methods of rescue that preserve the dignity of those being rescued or the handling of bodies can have a significant influence on the psychological recovery process for all involved' (Gibson 1994: 139).

Those responding in the medium and longer term after major emergencies should also adopt a rights-based approach in relation to specific issues such as: the viewing of the body; access to information about body recovery, identification processes and post-mortem reports; opportunities to visit the site of an incident; and decisions about how and when property is returned. Experience has shown that where these and other elements of disaster response are poorly managed the stress levels of already traumatised people are likely to significantly increase (Erikson 1976b; Eyre 1998). All responders should also be aware of the role of police family liaison officers after major incidents and the principles and guidelines underpinning their deployment in relation to these rights and recommendations. In this respect the Macpherson Report (1998) following the death of Stephen Lawrence should be essential reading on training and education programmes relating to psycho-social preparedness and response. Furthermore, accreditation programmes should reflect principles and standards of care discussed in rights-based approaches.

The forms of provision in relation to different phases discussed forthwith are summarised in the Model of Phased Provision in Appendix 1. This model depicts key reactions, needs and provision at different levels of humanitarian response and has been developed with reference to the phases identified by Zunin and Myers (1992) discussed earlier.

Immediate Aftermath: Needs and Support

Sometimes referred to as the short term immediate crisis phase, shock dominates the initial reactions of those affected by disasters. Shock can bring psychological numbness and an inability to concentrate or to comprehend information. As discussed above, there can be different reactions to shock in terms of the degrees of activity or passivity people exhibit and their associated emotional reactions; for example, some survivors report initial feelings of euphoria and energy at their survival which later give way to feelings of guilt that they survived when others perished. For those physically injured too, the numbness of initial shock may give way to the reality of their own injuries and thoughts about how their future lives may be affected while for those bereaved, shock may be replaced by awareness of the harsh reality as more information becomes available.

Gibson highlights the importance of an appropriate and measured approach here: 'To provide support … at this stage will require a team who can be proactive in their approach but do not overwhelm highly vulnerable people' (1994:139). Indeed, she expands on the sort of help that is commonly referred to as 'psychological first aid', that is to say practical and emotional support to those in distress. Gibson describes this practical and emotional support as consisting of the 8 'T's:'tears, tissues, talk, tea, time, telephones, toilets, transport' (1994:139).

The linking of both emotional and practical support is especially important to note and understand here, not least because it is often misrepresented as 'counselling'. Indeed media accounts of counsellors descending on disaster scenes are usually based either on misinformation or an

inappropriate response. Support based on providing basic emotional and practical assistance is what is most needed at this stage. Myers reinforces this in her handbook on disaster response and recovery for mental health professionals, stressing also the resilience of survivors under stress:

'Most disaster survivors are people who are temporarily disrupted by a severe stress, but can function capably under normal circumstances. Much of the mental health work at first will be to give concrete types of help (Farberow and Frederick, 1978). Mental health personnel may assist survivors with problem-solving and decision making. They can help them to identify specific concerns, set priorities, explore alternatives, seek out resources, and choose a plan of action (American Red Cross, 1982)' (1994: chapter 1).

Newburn reinforces the fact that 'engaging in practical support early on is of crucial significance', not only because it can be of significant value to families and survivors at particularly difficult times, but also because it may enable the worker to establish some credibility and trust (Newburn 1996a:15)

Proactive Outreach and Support

Proactive outreach and support has been highlighted as very important from this earliest stage, both with those directly involved at the site of an incident or close by and with those who are likely to have been bereaved. This is where the quality of pre-planning for organised care makes a difference and becomes operationalised.

Transport-related organisations may regard themselves as having a particular role to play in the provision of help to families and thus local authority or other types of outreach programmes should take account of and be run in conjunction with these. Within the airline industry for example, ICAO recommends that its contracting states and airline operators prepare a plan for family assistance which includes the following types of support after an aircraft accident:- confirmation of the involvement of a family member, immediate financial assistance and other practical and emotional support (such as assistance with travel, immigration and customs formalities, accommodation while away from home, information briefings, travel to the accident site, memorial services and access to mental health care). In terms of staffing this response ICAO (2001:5) cite experience showing that an average of four to five contact persons per family may be required to ensure the flow of information within a family.

In the hours following an incident, the demand for information and confirmation about who is involved becomes of paramount concern. While the authorities (including the police) will be keen to gain information about the identity of those involved (for evidential purposes as well as in order to meet their psycho-social needs), information about loved ones will be families' overriding priority. Thus facilitating and supporting access to this and other types of information, within an appropriate environment, is central to psycho-social support at this time.

Under the Civil Contingencies Act (2004) local authorities play a crucial role in preparing for and supporting this outreach response within the UK. The sorts of services this might involve include liaising with the Benefits' Agency and other government welfare agencies on behalf of clients; ensuring welfare services to 'at risk' clients are continued along with the identification of new clients created by the major emergency; providing accommodation, staffing information services and drop in centres and liaising with other agencies (such as health services) in relation to the provision of a joined up service for clients.

Where an event happens outside of the UK but involves UK citizens, the public increasingly expect consular services to be part of a frontline proactive response. In recognition of this the Foreign &

Commonwealth Office (FCO) has increased it capability to respond through the establishment of Rapid Deployment Teams (RDTs) within its Consular Directorate. These can be despatched within hours of a major crisis occurring anywhere in the world (Cabinet Office/ACPO 2006). The primary role of such teams is to ensure that British victims and their families affected by an incident receive the highest possible level of consular service in the shortest possible time.

As part of its increasingly proactive approach to planning and response the FCO has also developed the role of its Emergency Response Team (ERT). The function of this in an incident is to provide a central contact and information point for all records and data relating to persons who have, or are believed to have been involved in an incident overseas. Multi-agency planning has facilitated the joint working of the ERT with police Casualty Bureaux in order to increase call handling capability in processing inquiries.

Such relatively new initiatives will require testing and evaluation, in order to identify the extent to which the aim of proactive support is achievable and satisfactory in response to future incidents. Feedback from actual and potential users will be important in measuring the success of such procedures and opportunities for ongoing improvement in their provision.

Privacy and Confidentiality

The processing of inquiries and data in both these initial and later stages of disaster management highlights the importance of agreeing protocols for the sharing of information, such as details of bereaved families or survivors. In recognition of the ethical issues this area beyond simply meeting the requirements of the Data Protection Act, Disaster Action (2006) has produced a code of practice aimed at protecting the rights and interests of those affected by disaster, specifically survivors and the bereaved. It is designed to govern the attitudes and behaviour of all those who may work directly or indirectly with all those affected by disaster. It includes, but is not limited to, local authorities, coroners and all those involved in identification processes, members of the emergency services and investigation teams, National Health trusts and voluntary agencies.

Discussion of this code and the practical implications for all involved in humanitarian response should be included in the planning and training stages of disaster preparedness. It should be recognised that the right to privacy and confidentiality in relation to information and data-sharing is just as important as privacy and confidentiality in terms of providing closed and quiet meeting rooms for families coming together in the aftermath of an incident (ICAO 2001:6).

Helplines

The provision of a helpline, with trained personnel to deal with the calls, will be of vital importance during the immediate post-crisis stage after incidents, particularly if or when it becomes difficult for callers to access Casualty Bureau or other services. Experience has shown that the main functions of helplines in the early stages post-event are to provide information on ongoing help and to receive offers of help (Henwood 2005:4). Later their role may extend to providing or assisting with referral to counselling support (Gibson 1994:139). Where possible to resource, 24hour/7 days a week helplines have been regarded as a major back up to a proactive counselling service (Newburn 1996a:20).

Staffing this type of resource can be challenging though and where volunteers are used it is important to ensure that appropriate levels of skill and experience are available, including familiarity and experience in dealing with trauma and bereavement (Henwood 2005:4). Training and preparation for the necessary resourcing of such helplines, in terms of personnel and physical facilities, is thus a key element of psycho-social emergency planning.

Family Liaison and Personalised Support

Personalised support to the bereaved from the earliest stage has been found to be particularly helpful after disasters. Building on lessons form the past, a single point of contact for bereaved families and injured survivors has been recommended by many and becomes especially useful in relation to liaison between families and the large number of organisations likely to be involved in disaster response. Written information explaining the role of differing providers, their contact details and what they might offer has been found to be useful for families. ICAO (2001) refers to how one state produced a pamphlet with these details. An example of this becoming standard practice, is the information that was also collated and distributed to visitors to the 7/7 Family Assistance Centre in July 2005.

In past disasters a collaborative and structured approach to psycho-social support has enabled personalised help to be available for each family group. Where this can be resourced by appropriately qualified people and works effectively it can increase the confidence and reassurance of families. After Kegworth, such helpers assisted with meeting and briefing relatives arriving at the hospital, accompanied them in visiting patients and escorting them to private areas afterwards (Gibson 1994:139).

After Hillsborough, social workers were used to provide a strong element of 'personal support', accompanying people to a wide variety of public and private events and adopting a befriending role, essentially 'being there' for people not just in the early days, but later on when other sources of support had disappeared or when particularly stressful occasions arose. (Newburn 1996a:20). On first contact two factors were identified as having been crucial in determining whether the first approach made by a social worker would be likely to lead to further contact and to some form of relationship being established. They were 'firstly, the extent to which and the manner in which workers made clear what their purpose in calling was; and secondly, the time and the way in which the first contacts were made. Workers' ability to present a straightforward and positive reason for calling was central in overcoming resistance to social workers' (Newburn1996a:20).

As stated earlier, it is now recognised that local authorities should take responsibility for coordinating the provision of welfare support to the community (Cabinet Office/ACPO 2006). In some areas this has included the development of strategies for offering personalised psycho-social support through crisis support teams and psychological support teams. It is important that anyone serving as part of an organised welfare response is appropriately trained, qualified, experienced and integrated into an overall strategy for community and social psychological support. Currently, however, there are neither nationally agreed protocols for such teams nor professional standards or accreditation for those working who might deliver such services. Work is being coordinated by the Department for Culture, Media and Sport through a Training Accreditation Standards Working Group; this is a multi-agency initiative including input from national organisations such as the Social Care Institute for Excellence, the Association of Directors of Social Services and the Sector Skills Council. As this work progresses towards establishing nationally agreed concepts and operational protocols it will important to include the involvement of bodies such as the Local Government Association, the Association of Chief Police Officers, the National Health Service, the Society of Local Authority Chief Executives and the Voluntary Sector Civil Protection Forum.

It is important that both those involved in psycho-social support and police FLOs understand their relative roles and remits and that those coordinating police family liaison work closely with those coordinating overall psycho-social support, including social services professionals. In the 1990s the development of family liaison within the police service has made a significant difference to the way in which personalised support has become accessible and available for bereaved families (and in

in which personalised support has become accessible and available for bereaved families (and in some cases injured survivors) following disasters. The primary function of a family liaison officer (FLO) is that of an investigator; that is to say they are not primarily support workers but rather are deployed to assist in the investigation of deaths and identification of those killed in mass disaster (ACPO 2006:10). In performing their role as investigators, however, family liaison officers will offer, give and facilitate support in relation to the needs of the family to which they are deployed. Principally though their role is to manage the partnership between the family in the investigation and those managing identification and investigative functions within the police service.

Facilitating Contact and Mutual Support

Depending on the circumstances of any particular disaster, in the immediate aftermath survivors and the bereaved may already know, expect and have the information necessary to be able to remain in contact with each other. This may occur for example where a particular community, school/workplace or organisation is involved. Very often however this would not be the case, and once survivors and the bereaved return to home or other places of safety, a wish and desire to be in contact with others directly affected by the tragedy can become strong. As discussed earlier this is a common experience for those who are bereaved or survivors from traumatic events and concurs with the findings of reviews of effective psycho-social support such as Norris et al's (2005) which found that received and perceived social support, including the belief by survivors that they are cared for by others and that help is available if needed, makes a significant difference to levels of psychological wellbeing after disaster.

Mindful of the issues associated with privacy and confidentiality above, those providing psycho-social support should plan for and address such wishes and requests for assistance with contact details and opportunities. Providing psycho-social support includes facilitating opportunities for those seeking out others to have the opportunity to be in contact and meet informally as soon as possible after the event.

This might be achieved by setting aside a comfortable and private room in a reception or assistance centre (as happened 10 days after the July 7 bombings) or by a providing a room in a local hotel. As Anne Bone learnt after the Piper Alpha disaster, such a meeting for survivors might not only include those locally based, but attract attendees from much further afield (1996:28). After a first initial meeting her role included continuing to arrange similar links and support groups for bereaved families in the following months.

Opportunities for facilitating contact between those affect by the tsunami were explored by the Tsunami Support Network (TSN) in the months after the disasters; however it was not until five months after the disaster that this occurred when the first organised meeting of families was arranged. Understandably there was frustration on the part of some survivors and the bereaved that such opportunities for meetings did not take place earlier. Reasons for the delay included difficulties in identifying how many and who had been involved as well as the concerns about sharing different organisational databases. As discussed above, attention should be paid to gathering details of those involved in incidents as well the development of protocols for sharing information.

With the TSN there were also concerns about setting up an unmoderated online chatroom as a forum for mutual contact without appropriate mechanisms for safeguarding and supporting subscribers. A lesson learnt was that if the desire is there, individuals will circumvent official channels and set up their own opportunities for networking through, increasingly, the internet. This indeed happened with a number of websites and chatrooms being set up by those bereaved and survivors from the tsunami from the first few days after the disaster.

Following the July 7 bombings the police facilitated the setting up of a secure online discussion forum for the bereaved and survivors, including a private section for the bereaved. Issues relating to the implications of such communications for witness statements and evidence need to be considered further here and also the appropriateness or not of an organisation like the police setting up such a forum. Security and privacy for subscribers again needs to be considered carefully here. More work should be done then to evaluate the potential for internet based discussion forums, moderated or otherwise, to be included in psycho-social planning Helpful reference might be made to users' evaluations of the experiences of the Tsunami Support Network forum, the July 7 discussion forum and other similar web-based forums in this regard.

Addressing the Disillusionment Phase

Many case studies have documented the gradual demise of the helping relationships that emerge in the initial aftermath of disaster. This tends to occur once the outpouring of post-disaster funding, services and public/media attention starts to fade (Drabek 1986:202). Bone's reflections on this period in the aftermath of the Piper Alpha disaster is typical; she comments on how, within a couple of weeks after the disaster, many of the relatives returned home, dignitaries completed their visits, and the media and press left to chase another bigger story (1996:27). For Bone and her colleagues there was still very much work to do.

This phase of disillusionment is important to both acknowledge and expect once emergency actions are completed as it marks an important transition for both those directly affected and those involved in providing the next phases of psycho-social support. This period is usually marked by a return to 'normality' in terms of usual services and bureaucracies and can be when reactions associated with individuals' or departmental fatigue and stress can start to manifest. Pre-planning and response strategies should consider the impact of the longer term effects of disaster after the immediate emergency phase and the implications for organisational resourcing and rehabilitation once this phase begins. In turn exercises and audits should test plans in place for addressing this element of continuity and resilience which may not be recognised as a key part of the psycho-social disaster cycle.

For the bereaved and survivors this phase marks the transition from shock through to the gradual realisation of the impact and consequences of their involvement in the disaster. This can be the time when it really dawns that there can be no return to the past but only the beginnings of adaptation to a new normal. Drabek states that seasoned practitioners have observed that this can be the time when hostility is vented at those trying to help, even though they may be there solely to help and may in reality be undeserving of the focus (1986:203). Those making strategic decision about forms of psycho-social support should be made aware of and take account of the fact that services may be needed *more* rather than less as this stage is reached and that demands may become greater. For responders this may come just as their own personal and organisational resources become more vulnerable due to insufficient pre-planning for ongoing support.

Key Points

- The emphasis on interventions should be on empowerment i.e. drawing upon resilience and building strengths, capabilities and self-sufficiency.
- A thorough understanding of the phases of disaster, as well as focused attention to the phase that individuals are experiencing, is essential to successful outreach.
- Reports and guidelines on principles and standards of care grounded in rights-based approaches should be included in emergency planning, training and education.
- Proactive outreach support, including personalised support for bereaved families and contact between those affected, has been found to be most helpful from the earliest stages.
- Providing psycho-social support includes facilitating opportunities for those seeking out others to have the opportunity to be in contact and meet informally as soon as possible after the event.

Further Reading

Cabinet Office (2004) Civil Contingencies Act: Emergency Response and Recovery, Non-statutory guidance to complement 'Emergency Preparedness', HM Government (www.ukresilience.info)

Cabinet Office/ACPO (2006) Humanitarian Assistance in Emergencies: Guidance on Establishing Family Assistance Centres (http://www.ukresilience.info/publications/facacpoguidance.pdf)

Clarke, Lord Justice, 2001, Public Inquiry into the Identification of Victims following Major Transport Accidents, HMSO Norwich

Disaster Action (2006) Working with Disaster Survivors and the Bereaved: Code of Practice on Privacy, Anonymity & Confidentiality (http://www.disasteraction.org.uk/guidance.htm)

Medium and Longer Term Phases of Support

Ongoing Provision of Information

Strategies for continuing to outreach and provide information for those impacted by disaster are essential if psycho-social support is to be effectively available and accessible to those within affected communities. As well as media and communication strategies to the general public, the provision of information briefings for bereaved families and survivors (together and/or separately as appropriate) and written leaflets for distribution at significant sites is important. Such sites include not only designated reception and assistance centres associated with the event, but existing facilities within communities such as workplaces, schools, community centres and GPs surgeries. Dissemination of specialised briefings such as the GP Alert after the 2004 tsunami should be followed up in order to maximise the effectiveness of such communications and the take up of services where needed. This may require a national directive within the Health Service in order to encourage individual strategic health authorities to implement an agreed approach. More work

needs to be done to engage health service providers more actively in strategic planning and response initiatives before and after incidents.

Information Briefings for Families

ICAO (2001:7) makes the important point that the provision of a continuous flow of information is fundamental to effective family assistance programmes. Information briefings to bereaved families is central to this and those undertaking investigations of incidents and the identity of those involved may arrange for private group family briefings. Such briefings should be carefully planned and structured in order to address both the practical and emotional needs of those attending (see Disaster Action below).

Police family liaison officers are also likely to be a key conduit of information to and from bereaved families in the weeks and months following an incident. Effective coordination and communication from FLO coordinators is essential if these officers are to be successful as single points of contact of families. Good liaison between FLO coordinators and those coordinating psycho-social support is also important in order to maintain the flow of information about the processes of investigation and the availability of support services. The Cabinet Office multi-agency strategic coordination meetings that took place firstly after the tsunami and then after the July 7 bombings provided a good basis for such multi-agency coordination and communication. This is an example of good practice that could be modelled for future events.

Site Visits

In the aftermath of disasters, the places where tragedy occurs and other significant sites associated with the disaster become focal points for grieving and commemoration. As discussed elsewhere (Eyre 2006) the perceived extent of tragedy is often symbolically expressed in the number and status of official visitors to the scene within the first few days. Emergency managers responding in the initial days and weeks of an incident often find themselves preoccupied with organising the itinerary, security and media management of such visitations, including public statements of shock and sympathy as well as visits to the injured in hospital.

It has been recognised that visits by the bereaved and survivors to key sites are extremely important after an event. These should be facilitated by those coordinating and providing psycho-social support as part of the grieving process. ICAO (2001:6) details the additional practical considerations that should be included as part of such planning and provision for after aircraft accident sites. Building on experience, they comment that the family members of those killed in an accident prefer not to share the visit to the accident site with survivors (ICAO 2001:6).

Organising such site visits effectively requires careful attention to a number of practical, logistical and psycho-social concerns and should be undertaken by those appreciative of the enormous significance of details and sensitivity in relation to these. The roles and responsibilities of site visit coordinators include: management of visits by bereaved families and survivors; the meeting and greeting and ongoing support of those arriving on site; preparation and briefing of visitors; facilitating access and egress to the site; managing privacy, opportunities to leave flowers and other mementoes; addressing cultural considerations including faith-based beliefs and practices; managing the amount of time available and timings of visits; control of the media; and liaising with other agencies regarding the impact of visitors on the welfare and support of staff on site and in the surrounding area. All of this demonstrates that ideally a specialist team should be deployed made to coordinate all such visits.
In the weeks after the July 7 bombings the police invited bereaved family members to an information briefing and visits to the four sites of the attacks in London. In assisting with the

preparation for these meetings, Disaster Action provided helpful advice and highlighted a number of important considerations. Those conducting future briefings might take into account such considerations by referring to this organisation before such meetings with families.

Identification, Custody and Return of Human Remains

The identification, custody and return of human remains are very important forms of family assistance and opportunities for viewing bodies and remains is an essential part of psycho-social support. Anyone involved in planning or coordinating the support of families in relation to these issues should refer to the guidance issued by Disaster Action on Disaster Victim Identification (2005b) which, though written designed with specific reference to FLOs and Coroners officers, contains helpful and relevant information for other responders also.

Viewing the body of the deceased is recognised as an important part of accepting the certainty of death, especially in sudden and unexpected death. 'In the absence of a body, this certainty, which is necessary for effective grieving to begin, may never be established. If the body is recovered, but not seen, this may in certain circumstances lead to a failure to establish this certainty, and in others, to a delay' (Hodgkinson and Stewart 1996:35). Drawing on their personal experiences of bereavement, members of Disaster Action stress the importance of creating a facility whereby family members can see and be with their loved ones after death and highlights the importance of informed choice in this regard: 'After a disaster, regardless of the state of the body, family members may wish to have the opportunity to see that person before the remains are returned home or to the place of burial or cremation. Others may not wish to do this, but we believe it is vital that facilities are created to make this possible and that all effort is made to facilitate opportunities to view' (2005b).

Lord Justice Clarke's Inquiry Report into the Identification of Victims following Major Transport Accidents has reinforced the view that families should have a right to views bodies if they wish to do so. As Disaster Action have observed, sometimes for the best of intentions, it might be felt that viewing bodies should be denied for the sake of protecting people. 'However it is now understood that exercising the right to view is important for the future psychological well being of families, as well as in some instances for identification purposes. Being prevented from exercising this choice can have a long-term detrimental effect' (Disaster Action 2005b).

In relation to the return of remains after disaster and offering support to families, Disaster Action discusses the importance of being aware and addressing the complexities and potential differences of opinion within families, particularly where conflict and disagreement might arise. In circumstances where differences and disagreement surface they state that where possible, a solution should not be imposed upon families; rather they should be facilitated in their need to resolve such conflict themselves, with outside help if necessary (2005b). In the case of prolonged processes of identification and recovery over a long period of time, Disaster Action stresses that wherever possible, at an appropriate stage in the process, families should be offered the choice as to whether or not they wish to be kept informed of the recovery of any further remains, however long the process. Psycho-social support here includes making available accurate information 'in a sensitive manner, at an appropriate time and place and always on a face-to-face basis' (Disaster Action 2005b).

Protection and Return of Personal Effects

In the aftermath of traumatic loss through disaster the protection and return of personal property is often of huge emotional and symbolic significance to survivors and the bereaved. For this reason the families and the survivors will need reassurance that arrangements have been made to ensure that personal effects will be correctly handled and returned to their legal owners. Eyre and Payne

(2006) discuss the practical procedures and emotional implications associated with recovering and returning such property and the importance of conducting communications and transactions in a sensitive and appropriate manner: 'Being presented with a black bin liner and a form to be filled in gives one message; receiving a carefully prepared package accompanied by a few thoughtful words gives another' (2006:35). They reinforce the need for emergency planners to revisit their plans and guidelines in relation to the return for personal property in order to take account of the increasing emphasis on a rights-based approach to disaster management. This includes considering the wishes of families in relation to the cleaning of property before return and giving consideration to the fact that families should be given sufficient time to change their mind in relation to the return of items.

Psycho-social support here might include facilitating access to information and decision-making processes with regard to the viewing and return of property. It might also include providing physical and emotional support during the handing over of records for viewing pictorial images of property and during the process of final return (Disaster Action 2005c).

Financial Support and Disaster Funds

As well as the need for immediate financial assistance generated by being involved in a major incident, the medium and longer term economic impacts of disasters can be extensive on individuals, families and communities. Financial losses and economic ripple effects may include, for example, temporary loss of income and/or permanent inability to work (through long term injury and/or disability), the loss of a main breadwinner(s), and the loss of home, workplace and/or property (which may not be covered by insurance, for example in flooding disasters). Even where financial assistance is made available, problems often abound in the way in which such support is administered and distributed and individuals may fall through gaps in terms of eligibility to services. This has been found not only fail to mitigate the physical effects of disaster, but can exacerbate the psychological stress of those directly bereaved and/or injured.

As well as formal mechanisms such as the Criminal Injuries Compensation Authority, other forms of financial support such as charitable donations and disaster relief funds have become a common response to disasters since the nineteenth century. Following the extensive media coverage of disasters, one way in which the public respond today to such tragedies is through spontaneous donations to disaster funds. In many cases several funds may be established with extensive public response.

However, few information sources are available for those charged with setting up and administering such funds in the immediate aftermath of incidents. While local authorities continue to engage in emergency planning to address community needs after disaster, limited guidance is available to them and other responders on how to manage disaster appeal funds. This helps to explain why, as Mclean and Johnes have shown, 'they are often fraught with potential problems that can further distress those whom they are designed to help' (McLean & Johnes 2000:134).

In 2004 Disaster Action conducted a preliminary review of existing guidelines and discussions with victims of disaster. They found that although disaster fund trustees have access to the Attorney General's and other guidelines on the subject produced by the Charity Commission and the British Red Cross, these do not offer much direction. Furthermore, their communications with those on the receiving end of disaster funds highlighted that the bereaved and other victims are often left unable to claim against a full fund and are unable to understand the rules concerning why they do not meet criteria set by others. People are often left uninformed and upset about the ways in which funds are administered and distributed. Currently there is no written advice or guidance aimed specifically at those who may be recipients of fund proceeds which might explain the procedures and implications of fund administration.

Since Disaster Action's review, the effects and responses – both public and organisational – to more recent events such as the tsunami, the July 7 bombings and the Sharm-el-Sheikh terrorist bombing, have further reinforced such concerns about the continuing difficulties and problems associated with the financial consequences of disasters and disaster appeal funds. Recent events have highlighted how, as well as the practical issues associated with long term financial need after disasters, there are significant symbolic meanings and messages relayed through the granting (or withholding) of funds as well as the way in which they are managed and administered. Addressing these issues thus requires understanding and responding to the expectations and perceptions of both donors and recipients about the meaning attached to financial assistance and its management.

More research and practical guidelines are clearly needed in this area. These are important for addressing the philosophical and practical issues related to addressing financial hardship after disasters as relevant to both responders and recipients.

'While the intention of appeals is to alleviate the distress and also financial hardship suffered by the bereaved, the effect is often to add to rather than alleviate distress. There continues to be a mismatch in the perception of donors, trust fund managers/trustees and recipients/non-recipients about who the money is intended for and how it should be spent…..We believe there is a need for further information and guidance to close this gap between intention and outcomes' (Disaster Action (2004)).

Support Groups: 'Action Groups' and 'Facilitated Talking/Support Groups'

In the weeks and months following disaster different kinds of support groups may function to provide practical and emotional support for those directly affected by disasters. Two types are detailed here. The distinction between them is important when considering the nature and way in which support for their activities might be organised and funded. In practice groups might fulfil the functions of either one or both of the ideal types referred to below, and indeed there may be a number of groups associated with a disaster which fulfil these differing functions.

a) User-Based Action Groups

During the decade of disasters in the 1980s many *user-based action groups* emerged, set up and driven by those directly affected by particular disasters. Their constitution consisted of either bereaved family members or survivors or sometimes a mixture of both. In the absence of coordination and central information points such as those now provided through FLOs, such groups emerged to provide mutual support, share information and activate collectively for the pursuit of common goals such as information, the prevention of similar incidents and/or legal outcomes (Spooner (1990)). Examples of bereaved family support groups include those set up after the disasters at Zeebrugge, Lockerbie, Hillsborough and the Marchioness Riverboat sinking. Some funding for the activities of these groups came from appeal funds or charitable donations. In considering funding, maintaining *political independence* was very important for these groups, particularly when the group's purpose included general campaigning or the pursuit of a particular cause such as pressing for re-inquests, a public inquiry, or action in relation to safety. For these reasons such groups often conducted their own fundraising activities and organised their own independent memorial-related activities.

Earlier we stated that part of any psycho-social support strategy should be to support the opportunities for people to be in contact with and meet each other. Organisers should understand and expect that for some people developing and joining this kind of self-help group may be an important part of their recovery. Discussing the development of disaster community support

networks, Salzer (2003) outlines how self-help group members provide emotional support to one another, learn new ways to cope, discover strategies for improving their condition and help others while helping themselves. ‘’By offering a community resource to anyone in the community, self-help groups strengthen a whole community’s ability to cope and heal. Bringing people together offers the potential for group action or advocacy efforts, which empower both individuals and the community’ (2003:21-22). Spooner reinforces this point about the functional value of such activities:

‘People bereaved by a disaster…- or afflicted by the psychological shock of having survived one – are consumed by a mixture of grief and anger. Those emotions are inescapable but quickly become destructive. The only remedy is to channel them into a constructive activity’ (1990:6).

At the same time, in developing psycho-social support strategies alongside these activities, funders and organisers should keep in the forefront of their minds two key factors which might prevent them potentially being placed in a conflict of interest in relation to the conduct and running of such groups:-

(i) being in control and taking responsibility for the establishment and running of such groups may be an important psychological element for members leading and participating therein. (Enablers should be mindful of the potential disempowerment caused by running a group *‘for’* those directly affected).

(ii) the independence of a group may be a fundamental principle for members wishing to maintain their freedom to engage in activities, particularly where such activities include political activism (Kings Cross United, for example, are very actively seeking a public inquiry into the London Bombings).

There is a clearly a difference here between *enabling* (e.g. in providing practical assistance such as with meeting rooms, etc) and *facilitation* (see below). Those involved in psycho-social strategies running parallel to user-based initiatives should recognize and respect the independence of such groups and beware of becoming over-involved in either organising or funding their progress. This may be a difficult path to follow given the way in which organised support, including government-linked support may now be expected after disaster, but clarity about these principles and the rationale behind them should be helpful in informing any specific strategy. Organisations such as ICAO recognize and reinforce this importance of balancing support and empowerment: ‘If requested by the families and the survivors, the operator and government agencies should be prepared to support the establishment of family associations. It is essential that such an initiative originate with the families and the survivors’ (2001:8). Disaster Action has produced helpful practical advice for those wishing to set up their own support groups (Disaster Action 2005a).

b) Facilitated Talking Groups

A second type of group which has developed after previous incidents is facilitated talking groups. Examples of these include those established after Hillsborough, the Oklahoma City bombings (1995), the September 11 attacks and the Tsunami. Although their functions may overlap with the groups described above, these groups differ from action groups primarily in terms of the way they are organised and their purpose which tends to be more focused on providing opportunities to share the feelings and experiences about the emotional recovery of members. They are more likely to be set up by those running a community support network than initiated by users themselves, with organisers providing a room for meetings, communicating with attendees about the time/place of meetings and often providing a facilitator for the meetings, or at least for initial ones.

Newburn (1996a:21) describes how opportunities for group counselling were facilitated after Hillsborough and how they helped survivors construct an understanding and make sense of events that day. As well as sharing accounts, opportunities to view video and newspaper material were vital here in helping people piece together what happened to them, as well as providing a means to encourage them to piece together what happened and talk about their experiences.

In the case of the Tsunami Support Network six such facilitated groups were run across the UK bringing together bereaved people and/or survivors to share in an unstructured format their experiences, feelings and strategies for dealing with the disaster. Typically these groups met for 3-5 meetings before the facilitator withdrew but through the Network enabled the groups' members to keep in contact with each other informally outside of this. Reflecting on what had worked well with these groups, the British Red Cross concluded that it was most helpful if facilitators had a background/training in counselling and bereavement and also specific understanding of trauma. Ideally, training and experience of working with people traumatised after disaster was recommended as an advantage. With the Tsunami Support Network three of the facilitators were members of Disaster Action and found that the combination of professional training and expertise in trauma as well as their own personal experiences of disaster gave them particularly helpful skills and understanding in being able to facilitate such groups. Drawing on these lessons, the following guidelines may be helpful for those running similar types of groups in future:-

- Be clear that such groups are not therapy groups set up and led by counsellors, but rather are facilitated mutual support groups to discuss experiences and personal recovery strategies;

- Have a flexible agenda and know from the beginning how many meetings will be run (In the case of the TSN it was agreed at the start that up to three facilitated meetings would be held in each area, though in practice some groups ran for slightly longer).

- Be clear that the groups are not a substitute for professional advice and treatment for individual reactions to disaster and know how/when to refer on.

In the United States, support groups were set up after the Oklahoma City bombings. Twenty-one separate support groups were established in the first two years after the bombing. They consisted of groups for survivors, parents who lost young children, parents who lost adult children, adult siblings of victims, widows and widowers, state employees directly affected, downtown workers and residents, rescuers and responders, school personnel, displaced persons, employee groups with multiple losses, and homeless persons who were in the downtown area during the bombing. Call and Pfefferbaum (1999) report how the groups were constituted on the basis of suggestions of individuals responding to outreach efforts. Group attendance and duration varied, but all were considered successful. They recommended flexibility in deciding what kinds of groups to offer, adapting to the changing needs and interests of potential participants.

Similarly after the September 11 attacks a number of organisations established support groups for those directly affected. One example (of very many) is those groups sponsored by Voices of September 11, a clearinghouse founded in 2001 for information and support for those affected. Since the disaster it has sponsored various types of support groups such as those for spouses, significant others, fire-fighter widows, adult siblings, rescue and recovery workers, survivors and witnesses, and parents of victims. This includes teleconference groups, the number of which more than doubled in 2005 to thirteen (Voices of September 11 2006).

Commemoration and Memorials

Religion, rituals and remembrance may play a fundamental role for those affected by disaster. Eyre (2006) discusses how religious organisations may combine their spiritual and practical roles following disaster. Indeed faith based groups are recommended to be integrated into psycho-social planning and response at local and regional level (Home Office and Cabinet Office 2005). Reference to and consideration of the faith and cultural needs of those affected by disasters should be included at every stage of psycho-social planning, provision and evaluation.

Following disasters spontaneous expressions of grief appear to be increasing rather than diminishing such that following the first news stories people will start to gravitate towards disaster-stricken communities to express their shock and grief. Flowers, candles, toys and other mementoes are often left at such disaster sites and associated focal points as these forms of convergence become management challenges for those tasked with organising disaster response and recovery (Eyre 2006).

Organised memorial ceremonies and services may be provided at these disaster sites and within local communities. Formal memorial services often follow some time after the initial aftermath of communal tragedies, allowing for a more extended period of planning and organisation. Their location, formality and content symbolise the sense, scale and significance of communal loss. In England, for example, official memorial services take place in local cathedrals or parish churches, with events marking disasters of national significance being held in London and attended by key national dignitaries (Eyre 2006).

In the UK the Department for Culture Media and Sport has become increasingly involved in formally organising official memorial services and guidelines for organising such services have been developed and refined through experience (Home Office and Cabinet Office 2005). Voluntary organisations including the British Red Cross are able to play a key role in assisting with providing practical and emotional support during the preparation, issuing of invitations, conduct of services and post-service receptions following such events.

Experience has shown that enabling families to participate in the planning and conduct of such services and memorial structures is also an important element of psycho-social support (ICAO 2001:8). In part this reflects a broader cultural shift over the last twenty years or so in favour of increased recognition of the needs and rights of the bereaved and survivors and their wish for participation in commemorative acts and rituals.

Permanent Memorials

Advances in technology and increasing use of the internet have resulted in the additional development of virtual memorials following disasters in recent years (Eyre 2006). A recent example of this was the 'We are Not Afraid' website (http://www.werenotafraid.com/) which included a page remembering the victims of the four attacks in London on July 7 with pictures and obituaries. As well as these, additional permanent physical memorials erected in the longer term aftermath serve important purposes in terms of personal and collective remembrance as well as bearing social and historical testimony to events of the past. It is increasingly expected that after a collective tragedy, some form or forms of permanent memorial will be constructed and the interests and concerns of those involved in family support groups often centres on plans and issues surrounding these forms of permanent commemoration.

Government funding has been used to fund some memorials (for example the Government contributed towards permanent memorials in memory of those killed in the September 11, Bali and

July 7 terrorist attacks). These however are seen as exceptions to the general rule that central Government does not fund memorials. Rather the financing of other permanent memorials has historically tended to come mainly from disaster trust funds including donations from the public. In Britain Charitable Law dictates specific use of charitable funds, which include their being used 'for the benefit of the community'. While some memorials are dedicated to other social functions, such as the building of a community hall, for example, others may be more specifically dedicated in memory of those who perished. Competitions inviting submissions of designs have also become a part of the process for the selection and construction of memorial forms (for example the design of the memorials after the September 11 attacks and in Khao Lak, Thailand commemorating those who died there in the 2004 tsunami).

It is increasingly recognised and expected that the bereaved and survivors are key stakeholders and should be consulted in planning the design and development of permanent memorials commemorating disaster (for a good example of this see the consultation framework established in Oklahoma City after the 1995 bombing and in Canberra following the Australian bushfires in January 2003 (Eyre 2006; Nicholls 2006)). Indeed many have argued that for those directly affected by disasters, consultation in commemorative processes and having a say may be integral, indeed fundamental, to the acknowledgement of trauma as a necessary pre-condition for recovery: 'Recovery requires remembrance and mourning. … Restoring a sense of social community requires a public forum where victims can speak their truth and their suffering can be formally acknowledged' (Herman 1997:242). As I have stated elsewhere, 'recovery requires a sense of social community in which people feel supported in looking back and looking forward. … It is only when this kind of support exists that survivors from disasters are really able to talk about recovery' (Eyre, 2004:27).

Those planning consultation and process should be mindful of this significance attached to the process of commemoration and memorialisation. They should also take account of the fact that the greater the number of consultees, the greater the potential for disagreement, dissent and difficult decagons-making. In setting parameters consultation processes should also take account of any restrictions that might prevail in terms of what might be practical and feasible in the design, cost and location of a permanent memorial.

The forthcoming fifth anniversary of the September 11 attacks is illustrative of the challenges posed by permanent memorialisation after disaster. The anniversary is beset with continuing controversy around the current condition and permanent commemoration of the site of the World Trade Centre (WTC). Nichols comments that such memorials to disasters are difficult to develop for a number of reasons, some of which concern purpose, emotional significance, 'ownership', recognition of and agreement among stakeholders, political response, and effective communication between communities and governments. She states ' the profound feelings of involvement of affected individuals and communities guarantee that controversy will probably accompany most if not all efforts to conduct any process designed to come up with an appropriate and acceptable disaster memorial' (2006:12). Her vivid description of the WTC site speaks for itself:

> 'The WTC post-11 September is an extraordinarily vexed and conundrum-ridden site. My overwhelming impression of the WTC restoration process was a sense of cross-purposes – the impulse to claim 'business as usual' in the face of the attack; the sheer, paralysing, impotent rage that such a thing could have happened; the imperative to staunch the haemorrhage of lost income from the most expensive vacant real estate in the world; the unwillingness or unreadiness of people to go back to their former workplaces at the site; and the profound grief still being worked through. Controversy surrounding redevelopment confirms this

impression. The banners shout: 'From recovery to renewal'. But recovery is not so easily or speedily achieved' (Nicholls 2006:7-8).

Key Points

- Strategies for continuing to outreach and provide information are essential if psycho-social support is to be effective.
- Visits to disaster sites should be expected and carefully coordinated.
- The identification, custody and return of human remains are very important forms of family assistance and opportunities for viewing bodies and remains is an essential part of psycho-social support.
- Attitudes and protocols relating to the return of personal property to the bereaved and survives should reflect a rights-based approach.
- While there continues to be interest in setting up and contributing to appeal funds after disasters, existing guidelines and practices have failed to prevent recent disaster funds from becoming 'second disasters'. More research and guidance is needed in this area.
- Different kinds of support groups may function to provide practical and emotional support for those directly affected by disasters. Coordinators of psycho-social support should be clear about the role and function of these groups and respect their independence where appropriate

Further Reading

Eyre & Payne (2006) 'Lost Property: The Role of the Police in Returning Personal Possessions after Disasters' in Australian Journal of Emergency Management (Vol 21 No 2 May 2006)

Eyre A (2006) 'Remembering: Community Commemorations after Disaster' in Springer Handbook of Disaster Research (Springer, New York)

Home Office/Cabinet Office (2005) The Needs of Faith Communities in Major Emergencies: Some Guidelines (July 2005)
http://www.ukresilience.info/publications/faith-communities.pdf

Salzer M (2003) Disaster Community Support Network of Pennsylvania: A Programme of The Mental Health Association of Southeast Pennsylvania, University of Pennsylvania
http://www.mhasp.org/help/dcsn.pdf

Inquests and Inquiries and Other Legal Processes

Few psycho-social disaster plans and exercises address and rehearse in detail the support issues associated with the legal procedures that often inevitably follow in the longer term aftermath of disaster. Drawing on the experiences of the decade of disasters, the Disasters Working Party Report recognised that legal processes such as inquests, inquiries and actions for damages such as compensation may be slow and cumbersome and found that following disasters in the 1980s information was often poorly communicated to all parties involved (1991:10). They recommended better coordination between support services, coroners and those conducting future inquiries

(1991:16) and acknowledged the important role investigations might play in understanding the causes and effects of events as well as contributing to the prevention of future disasters.

The provision of regular updates and points of contact for speedy access to sources of information is particularly important before, during and after such procedures. The development of police family liaison officers has made a positive difference to bereaved families in this respect, though much depends on the quality of coordination and communication during long and large scale deployments. Furthermore, over time such officers will inevitably exit from families and be in less regular contact which may have the effect of leaving families feeling uninformed and out of touch. Others, such as those injured but not bereaved and survivors, will not have a single point of contact such as a FLO and so may rely solely on updates from organised support networks or even the media for information. Liaison and coordination between the police, other investigators, those developing compensation packages and support services becomes crucial here and providing updated information through newsletters, websites and others forms of contact should be a key element of psycho-social support in the weeks and months after disaster.

Once an inquest or inquiry is opened (or re-opened) active support should be available to those attending and participating. Newburn highlights that disasters are not simply isolated or one-off events which recede into the background as the years pass. 'Disasters are followed by a series of events – official inquiries, inquests and so on – which are not only a vivid reminder of the tragedy but which, because they are not geared to the 'needs' of those affected by disasters, may exacerbate rather than mitigate suffering' (Newburn 1996a: 16). He calls for special provision to be made (including training) to enable support to be provided for families through the difficult and often expensive legal processes following disaster.

In previous incidents, such support has been provided by crisis support team staff; for example when the Piper Alpha official inquiry started 6 months after the disaster social workers operated a service for twelve months whereby each survivor was met and accompanied during the giving of their evidence if they required. They also supported the relatives while they listened to the most dreadful accounts of what went wrong (1996:29). After the 2004 tsunami the British Red Cross provided support staff to attend the inquest held almost a year after the disaster and good communication between the Tsunami Support Network and those planning and organising the inquest assisted the flow of information in preparing for this. However, despite links between the coroner, the police family liaison officers and the Tsunami Support Network, some families still reported feeling uninformed and unaware of the procedures involved. This is an important reminder of the fact that even where communication networks are in place they can be fallible and proactive monitoring of the effectiveness of communications is important to ensure those affected feel fully informed and have a platform for asking questions as and when necessary.

Why Investigations are Important

Formal investigations and their outcomes can play an important part in the psycho-social process of recovery. Research with those affected by UK disasters has highlighted the significance of the social, legal and political context of death through disaster for the grieving and longer term psycho-social rehabilitation (Eyre 1998). As discussed earlier, disasters involve *complicated* deaths in the sense that it is not always straightforward to establish the nature, cause and moment of death. This is important because these are questions which the bereaved and survivors want answers to and which can cause added anxiety in the personal, political and legal aftermath of disaster. They are often left with inconsistent, incomplete or conflicting accounts of how, when and where their loved ones died. Consequently in situations of mass tragic death the increased need to blame someone, as a feature of grief through sudden death (Worden 1991:99), often becomes focused on the responding authorities and the way in which they conduct their affairs.

As stated above, after humanly-caused events a feature of the British judicial system is long, drawn out and bureaucratic procedures. Although these are needed in order to conduct a thorough and comprehensive review of the evidence, the time-frame and bureaucratic manner in which they are conducted can also contribute to and prolong the emotional trauma of relatives and survivors. Worden states that such legal interruptions can delay the grieving process, but suggests that when cases are closed, this can help put some closure on grief (1991:99). Worden is focusing on situations involving a trial. However a common view expressed by those directly affected by disasters is that investigations post-disasters are not as thorough as a public inquiry and that few public inquiries into disasters in Britain have led to prosecution. This is why with many of the disasters in the 1980s and since, including most recently after the London Bombings, there are outstanding calls for full and open inquiries until which many of those directly affected feel there cannot be a sense of 'closure'. In the 1980s many of the ups and downs of ongoing legal battles left survivors feeling victimised by, and as angry at, the systems of inquest and inquiry, as they were at the facts of the deaths themselves (Eyre 1998). In some cases such legal processes continued for very many years, for example legal proceedings after Hillsborough and the Marchioness sinking were still ongoing 11 years later while today, almost 18 years on, an appeal is still pending for the man convicted of the Lockerbie bombing in 1988.

For these reasons it is so very important that the concepts of rehabilitation and recovery and notions of post-disaster support need to be understood and operationalised in a way that looks further beyond the first few months and years. It is argued here that in these latter phases of disaster it is also necessary to ensure that appropriate social, legal and political systems and structures are in place to respond to disasters since they will determine the nature and effectiveness of lessons learned as well as processes of accountability and responsibility and the ongoing impacts on those affected.

'We have to get people to understand that unless the inquiries are conducted properly, unless there are conclusions drawn, the families will not rest... (others) sometimes find it hard to understand why people continue to want answers to questions many years down the line... you continue to want justice but that message can sometimes be a little hard to get across' (bereaved relative, cited in Eyre 1998).

Supporting People in Relation to Legal Processes

It is recommended that training and education of those involved in providing humanitarian assistance after disaster should include raising awareness of the significance of legal processes for the psycho-social welfare of many of those affected. Gibson comments that providers should be sensitive to possible reactions to those identified as causal agents in incidents, not only in order to understand feelings of anger and blame but also because if an organisation is perceived to have been negligent it may affect the way in which practical help from them is received in the aftermath.

'Some may view it as an admission of guilt, demand more help as a right, or refuse such help as totally inadequate "blood money" in relation to the loss being experienced. These reactions occurred to a minor extent after the M1 plane crash, when British Midland ground staff did so much to help the hospitals and relatives of those injured' (Gibson 1994:136).

The Disasters Working Party Report (1991) also highlighted this potential conflict of interest, noting that families in the past have expressed doubts about the practice whereby a company which is in the process of being sued by a group of families will also pay the fees of the families' lawyers. It raised questions in their minds of who the lawyers were working for (1991:10). At the same time the report noted that victims have also commented on the positive role that companies can play when they demonstrate immediately their responsibility and concern for those involved in the

disaster, through public statements, personal visits, investigations, and financial support. ‘It seems to have been possible for some companies to provide all of this without prejudice to the issue of their legal liability’ (1991:11).

Those with personal experience have also stressed the wish also for those in political control of such decisions to be made more aware and more responsive to families’ concerns by understanding the impact of having to fight and continue to campaign for years after tragedy:

‘If they could only understand the level of ongoing anguish and distress the feeling of impotence can be when inquiries - criminal or civil - only come about because of pressure from relatives and survivors. I am again increasingly of the opinion that this lack of official 'enthusiasm' for inquiring into individual disasters has a much more profound effect than has been appreciated’ (personal communication with a bereaved relative).

Thus in the longer term, even after formalised organised psycho-social support has ended, it may be important for government to acknowledge and continue to be available and responsive to the needs of families where there are ongoing concerns and issues.

Adaptation, Closure and Recovery

For the reasons described above, notions of adaptation, closure and recovery may in practice seem more appropriate concepts for those outside of direct disaster experiences than those going through the ups and downs of the emotional aftermath of events. However, organisers need to have in place from the very start an appreciation of the importance of planning for their exit from the beginning rather than assuming to provide an open-ended service. Funders should expect this to be considered from the outset while at the same time including flexibility and ongoing evaluations of the most appropriate timing for transition, winding down and final closure of any service.

Gibson refers to adaptation as the end of the recovery process and the beginning of living life in a way that acknowledges the past and integrates the changes in a way that causes less pain (1994:141). She compares recovery from loss as being like the healing of a scar. The scar remains but as it heals it opens less easily and causes less pain. Providers of support need to understand and acknowledge that processes of recovery and adaptation will vary for individuals and know that the ending of a service does not equate with neat endings for those directly involved.

Systematic evaluation of services by users at differing stages for provision is an ideal way of gaining better understanding of the impact of service provision over time. However this is not standardised or even mandatory after any incident and few studies of disaster response include such systematic evaluation. Even where studies do exist, little has changed since Drabek commented that few include longitudinal designs go far beyond one or two year studies of the psychological impacts of events (Drabek (1986:261).

Further research and development of evaluation methods is needed to improve the nature and quality of data and analyses relating to psycho-social programmes after disasters. It is also important that such evaluations are conducted independently and that the implementation of recommendations is followed up and monitored. The development of the NAO report on the response to the 2004 tsunami is an example of a review conducted independently and it will be interesting to see its results. It also included the participation of service users in the design of the study as well as a methodological review by an external ethics panel, a fundamental necessity for any such study involving potentially vulnerable research subjects.

Key Points

- Formal investigations and their outcomes can impact on psycho-social processes of recovery and those providing support should be aware of this
- Good communication and coordination is essential between support services, coroners and those conducting legal investigations.
- Having to fight for legal procedures and accountability causes additional anguish for families and can render terms like 'closure' meaningless

Further Reading

Clarke, Lord Justice, 2001, Public Inquiry into the Identification of Victims following Major Transport Accidents, HMSO Norwich

Macpherson, W, 1999, The Stephen Lawrence Inquiry, HMSO London

Mead C (Ed) 1996 Journeys of Discovery: Creative Learning from Disasters, NISW London

Myers, D (1994). Disaster Response and Recovery: A Handbook for Mental Health Professionals. Rockville, MD: Centre for Mental Health Services (http://www.empowermentzone.com/disaster.txt)

Part IV: Humanitarian Response: Review of Service Provision

This part of the report reviews strategic considerations for those providing organised humanitarian assistance after disasters. It is based on lessons learned from previous forms of organised psycho-social support over the last forty years or so. After a brief historical review setting the scene for the development of organised psycho-social support in the UK, key principles are presented as the basis for planning and structuring support after future incidents. Examples of humanitarian assistance models including one-stop shop approaches are discussed and the lessons learned are highlighted as well as best practice pointers for the future.

The Development of Humanitarian Support

The historical development of psycho-social support after disaster can be traced back to the tragedy at **Aberfan in 1966**, at which time there were few trained responders available and no agreed or proven methods for supporting people affected by disasters (McLean and Johnes (2000:104)). Even so, local doctors and social workers in that aftermath of that disaster acknowledged that the community would need professional psychological and social work support. As highlighted earlier, one of the biggest challenges at that time was the acceptability within the community of such help given the fact that there was much less understanding then of trauma and bereavement and a reluctance to seek help for fear of being stigmatised (Madgwick 1996:45).

Initial practical help (such as assistance with filling in compensation forms) was provided by an advice centre which was quickly set up and staffed by the local Council of Social Service. The local authority decided to reject outside offers of counselling and psychological support in favour of local services, though this was limited to two psychiatrists and three local general practitioners. Plans to

bring outside help in to assist these limited resources seem to have foundered due to a lack of trust (McLean and Johnes (2000:107)). In addition to this, administrative divisions between the local education and health departments of the local authority hindered communication between those treating adults and children. Initially non-psychiatric help was limited by resources, basically two mental health officers and five social welfare officers who were not sufficiently trained for the job (McLean and Johnes (2000:108-9)). Eventually a family caseworker was funded by the local authority and provided an invaluable role – visiting families, providing listening support and encouraging the formation of bereaved support groups. After two years, though she felt the work was unfinished, the funding ended and so no further daily help was available (ibid:110).

Significantly community self help networks developed in Aberfan alongside professional help and became integral to people's recovery. This included a community association facilitated by the local council of churches. Earlier we discussed the importance of protective social resources and political factors affecting post-disaster recovery. At Aberfan obstacles to recovery included the arguments relating to the disaster fund (which became known as the 'second disaster'), political wrangling (including the government's two-year delay in removing the remaining tips), and cultural attitudes. In particular traditional male working class notions of masculinity meant male grief was denied rather than shared and faced (McLean and Johnes (2000:114)).

Later studies have given some insight into the longer term effects of this disaster within the community. Local GPs' records and psychiatric reports suggested significant levels of health problems. Resilience was also in evidence however with social workers at the time reporting that villagers grew out of adversity and benefited from the unity brought about by the disaster (McLean and Johnes (2000:117)). A study of survivors by Morgan et al over thirty five years later (2003) found that almost one in three children who lived through disaster had continued to suffer problems such as nightmares and difficulty sleeping. The study found that the intensity of the experience of disaster, a characteristic symptom of PTSD, was still very much present in some of the survivors' lives. The researchers concluded that children can be affected by traumatic events in a similar way to adults and are not necessarily more adaptable or malleable than adults.

As with other cases of PTSD, research after this disaster found that those with adverse reactions who did not receive help and support were vulnerable to reactions much later on. Wells (1995:24) cites the example of a woman who witnessed the disaster as a child of 11 went on to sue British Coal for damages claiming that the horrific scenes caused her to suffer a nervous breakdown 12 years later. She said that she blanked out the memory of the day until she read newspaper reports about a man and his children who died in a fire. The case only went to court in 1995.

Organisational responses to Aberfan reflected levels of knowledge and understanding of the time. As the years progressed many lessons were learned about psycho-social support after the series of man-made **disasters during the 1980s.** According to Hodgkinson and Stewart (1996) these events emphasised the total lack of preparedness of the health, social services and voluntary organisations for mounting long term psycho-social support. 'No social services department involved in any of these catastrophes had a plan which detailed the possible mechanisms for a psycho-social response to survivors, despite the fact that such departments are run by local authorities which have a responsibility for emergency planning (1996:71) They further reported that there was no coordination between health authorities and local authority social services departments despite being the two main statutory providers of care. (1996:72).

A this point there was still only preliminary understanding of the nature of the psycho-social effects of disasters, including post traumatic stress reactions, and the need to plan for a coordinated approach to emergency planning and response. Nonetheless, crisis support teams did respond instinctively and went on to share a common understanding of the need for more guidance and

preparation on how to meet the needs have those affected by future disasters. Whitham summed up their views following the publication of the Disasters Working Party Report (1991):

'Social service departments are now recognised as the key agency to lead the coordination of the immediate welfare response to the injured, their families and the bereaved. The staff who are called out by their departments to respond are likely to be faced with a harrowing and difficult task. They have a right to expect that effective plans exist for such eventualities, that they have had some relevant training and that proper coordination of planning has taken place with other agencies which might be involved in a response. Without this, chaos is sure to reign' (Whitham 1996: 38)

Common features of responses at this time included the setting up of crisis response teams, helplines, information leaflets and counselling services. The need for proactive outreach and better planning, training, accreditation and support for the specialist role of crisis response workers started to be demanded (Allen 1991). In the following decade, expectations of these forms of response increased such that today they would be expected to be part of post-incident provision.

Notwithstanding this, many of the ways in which bereaved families and survivors had been treated in the initial aftermath of disasters by the authorities in the 1980s had been deeply unsatisfactory. At times responses were characterised by a lack of preparedness, poor communication, insufficient cross boundary and interagency liaison and little support for families with regard to legal processes. Victims' disappointment at the ineffectiveness of organised support fuelled anger at the strong sense of injustice and calls for accountability in relation to so many predictable and preventable deaths. For many this was the impetus to join with others in forming family support groups and other associations. Members provided mutual support to each other and were galvanised into action through their anger at the ways in which the authorities and those tasked with providing help had compounded their trauma.

The umbrella group Disaster Action was formed out of just such dissatisfaction and motivation for change. An early publication stated: 'Disaster Action exists because people come together with like experience with the understanding that they know their lives have changed, with the knowledge that emergency planning is not all that it could be and that the human dimension of emergency planning, certainly in the past, has been missing... we try to supply it. And because of the nature of our experience we have credibility.' (Disaster Action 1990). Many of the bereaved and survivors from across different disasters who came together to form this charity in 1991, were united by the common feeling that it was not simply the fact of loss and the way in which their loved ones died that had made such an impact on the lives in the aftermath; it was also the way in which the bodies were dealt with after death and the way in which relatives were being treated in the immediate aftermath and since. Some felt that the events after the deaths were even as devastating as the fact of the death itself; in other words for them death was only the beginning of the disaster (Eyre 1998).

This is documented here because it illustrates not only the resilience of people directly impacted by disasters, but a further key point of relevance to anyone wishing to understand the impact of disaster, the needs of those affected and the implications for organised support. Not only are disasters themselves political events, in their causation and effects; so also are the activities of all those involved in responding, or failing to respond, whether it be in the form of direct political action (such as decisions regarding public inquires) or indirectly political action (for example in relation to the funding or provision of psycho-social support provided through a local/health authority). Disaster victims and their recovery are not immune from, but rather may be integrally bound up with and influenced by the broader political and cultural context in which disaster management is executed.

Thus when **in the 1990s, planning and response** in relation to the needs of victims in general, both living and dead, started to shift toward a more rights based approach, the treatment of disaster victims started to be discussed and planned with a new political and cultural emphasis. Events which influenced this development included the publication of the MacPherson report on the investigation of the murder of the Stephen Lawrence, the inquiries into the Alder Hey and Bristol organ retention scandals and the public inquiry following the Marchioness Riverboat capsize. Common to all of these reports were conclusions and recommendations focussing on the rights of victims.

Psycho-social responses to disasters more recently have started to reflect this developing approach. Additionally as the media reflects and influences public expectations about the level and standards of support which should be forthcoming after collective tragedy. Thus on the first anniversary after the 2004 tsunami, the BBC reported that the Foreign Secretary Jack Straw had apologised to British families caught up in the disaster who did not receive adequate support, adding that although Foreign Office officials had done a "fantastic job", it was not enough in some cases (BBC News 26 December 2005). He referred to British citizens these days having “very high expectations of what the British government can deliver - and fair enough."

With specific reference to psycho-social support, recent guidelines on the treatment or PTSD has outlined the nature of information, care, support and treatment that sufferers of PTSD can expect to receive from their GP and specialist mental health services (NICE 2005). Legislation such as the Civil Contingencies Act 2004 also sets the planning and provision of this and other psycho-social support within a statutory framework. In a very positive sense then we have come a long way from the days after Aberfan when the work of local welfare services after the disaster was deliberately not publicised for fear of making the situation worse (McLean and Johnes 2000:106).

Centralising Support: the ‘One-Stop Shop’ Approach

An interesting development in the way in which post-disaster support has come to be organised is reflected in the concept of a one-step shop approach to aftercare services. The meaning and application of such an approach has varied in relation to different disasters but basically reflects the belief in the value of having a **centralised place or gateway** (whether physical or virtual) through which those affected by a major incident or disaster may access services and support. The nature of such centralised support has included, for example, drop in centres, helplines and websites.

The one-stop shop approach relates not just to users being served in one place, but also to responding **organisations coming together collectively and collaboratively** to address at one place or point the needs of affected communities and discuss ways of targeting services to address those needs. The focus for such responding organisations may also be either a physical location/centre or non-physical network of communication (such as through virtual networks or a committee which meets at different locations at different times). Their focus might be strategic (e.g. a committee made up of senior organisational representatives such as the Cabinet Office meetings that took place in London after the Asian Tsunami and July 7 bombings) or operational (such as a local ‘unmet needs’ committee which discusses individual cases of ongoing hardship and tailored solutions).

Background to the One-Stop Shop Approach & Humanitarian Assistance

There have been a number of key developments in relation to the evolution towards this centralised and coordinated approach to support.

- As peacetime emergency planning developed over the last twenty years or so, UK emergency planning has reflected recognition of the need to establish short term physical support facilities such as Friends and Relatives Reception Centres and Survivor Reception Centres in the immediate response phase after incidents. These reflect a multi-agency approach and may be staffed by police, local authority staff and suitably trained voluntary organisations (Cabinet Office 2004: 37).

- In recognition of the medium and longer term needs arising from incidents, more recent guidelines also reflect the need to plan and provide also for coordinated longer term support. This includes, for example, plans for the migration to a multi-agency humanitarian assistance centre - or centres - which function as a singular focus for survivors, relatives and all those impacted by a major emergency (Cabinet Office 2004:37; Cabinet Office 2005). In principle this function might endure for an extended period of time, even if its physical location may shift and its name and/or administration may change (as happened for example with the centres set up after September 11 in the US and the July 7 bombings in London).

- Humanitarian assistance– or rather 'family assistance' as it has been more commonly known in this context - evolved in the US, particularly in relation to the passing of the Aviation Disaster Family Assistance Act (1996). This landmark piece of legislation, with international ramifications, formalised standards of care for families involved in transport disasters and has raised the bar for standards of care in other types of disaster. While the legislation requires that airlines formulate plans to effectively manage family assistance efforts after an accident, the impetus to proactively plan has been bolstered in the US and UK by other organisations becoming involved in planning. In the UK legislation such as the Civil Contingencies Act is reinforcing such a proactive approach.

- Longer term 'victim assistance' programmes were in place in both the UK and the US before 2001 (e.g. a family assistance centre was set up after TWA disaster in 1996 and in the UK physical support centres were set up after incidents at Zeebrugge, Hillsborough and Dunblane), but the events of 9/11 led to much larger scale demands for victim assistance and hence the implementation of facilities such as the family assistance centres set up at the Pentagon, in New York and in New Jersey. It was in building on such experiences that the Association of Chief Police Officers (ACPO) led initiatives in the UK to develop guidelines for family assistance planning after 2001.

- Generally in the last ten years in the US (which has been a key driver internationally), family assistance planning has became more prominent in planning from a corporate standpoint as well as from other agencies in the government and at state level and in the non-profit sector (NTSB 2006:1). The NTSB reports that in addition working relationships between industry, government and non-profits have solidified during that time, with professional understanding of 'family assistance' evolving from being considered ' very touchy feely' to being 'about providing information, along with the protective elements to prevent what we call post-accident secondary assaults, and unwelcome intrusions by the media' (NTSB 2006:1).

- As demonstrated in this review, in the UK longer term victim assistance and the extent to which a one-stop shop approach has been practically implemented has varied according to incidents, where they occurred and local providers. As discussed earlier, in the 1980s contact and assistance was in some cases actively deployed to the bereaved though social workers backed up by physical drop in centres and other coordinated networks of support centralised at local or regional level. From the 1990s developments in the police service have led to police family liaison officers also being more specifically trained and deployed

as part of a coordinated post-incident response to bereaved families. At the same time the one-stop shop approach has started to develop through the formulation of humanitarian assistance centre training and planning at local and regional level.

- Most recently the development of a lead government department for coordinating aftercare following disasters (the Department for Culture Media and Sport - DCMS) has included the establishment of a specific Humanitarian Assistance Unit within the Department focussing on disaster-related issues. Historically the term 'humanitarian assistance' has been associated more with NGOs engaged in independent disaster management efforts aimed at saving lives and meeting fundamental human needs such as water and sanitation, food, health care and shelter (see for example The Sphere Project (2004)). In relation to this UK context, humanitarian assistance relates to preparedness planning ahead of future incidents, disaster response in the period immediately following an incident; and the coordination of aftercare for those affected in the months that follow.

- Since 2005 the DCMS has been involved in a number of initiatives reflecting the 'one-stop shop' philosophy. After the Asian Tsunami (2005) it coordinated multi-agency strategic meetings at the Cabinet Office tasked with discussing strategic approaches to managing the longer term needs of those affected and similar strategic meetings for coordinated responses to the medium and longer term needs of the victims of the July 7 bombings. The DCMS also played a key role in supporting the establishment of the family assistance centre in London after the bombing and its transition to the 7 July Assistance Centre in Westminster in 2005.

The UK has been fortunate so far in not having had to respond in recent years to incidents on the scale of 9/11 and Hurricane Katrina, not only in terms of fatality and casualty rates but in terms also of the extensive economic and social impacts on the community in the medium and longer term. Documented accounts and discussions with those who have been directly involved in responding to such events emphasise some consistent key messages in terms of the lessons learned about one-stop shop approaches and the importance of proactive humanitarian assistance planning. These are summarised below after an overview of a few brief examples.

Examples of One-Stop Shop Approaches

The following case studies are included here to illustrate examples where support and information from a number of difference sources has been provided via a single point of contact (Appendix 2 includes a boxed overview of these and other examples summarising brief details of providers, services, funding and duration). The intention with the case studies below is not to suggest that these were the *only* forms of post-disaster support available at any point after these particular incidents, but rather to show how the concepts of a one-stop shop, and specifically family/humanitarian assistance centres, have been applied in practice in differing contexts.

Project Heartland, the first example, was established after the Oklahoma City bombings in 1995. This is included here because it was the first community mental health programme in the US specifically designed to intervene in the short to medium term with the survivors of a major terrorist event. The principle of using a multidisciplinary team approach aiming at providing culturally sensitive services to all those affected by incident was a priority also shared by the second case study from Dunblane.

Though a much smaller scale initiative, the Dunblane Support Centre is included as an example of a service set up in the UK. It built on the precedents and the lessons of UK provision in the 1980s and a service review at Dunblane included helpful user evaluation and suggestions for the future. The family assistance centres set up after 9/11 are then reviewed to illustrate the scale of needs arising

from a catastrophic event involving multiple sites and assistance centres. As said, the lessons learned from 9/11 reinforced the impetus in the UK for the development of humanitarian assistance guidelines for dealing with such scenarios. Finally, the virtual approach of the Tsunami Support Network is included to illustrate the use of a website as one aspect of a humanitarian assistance and recovery strategy.

The collective lessons learned from these and other models are included in the discussion of the costs and benefits of one-stop shop approaches that follow the case study examples.

1) Oklahoma City: Project Heartland & the Unmet Needs Committee

On April 19, 1995, a bomb exploded in front of the Alfred P. Murrah Federal Building in downtown Oklahoma City. This disaster resulted in the deaths of 168 people; 853 were injured.

Initially a family assistance centre – the Compassion Centre - was established by the American Red Cross, providing information (such as death notification) and support. On May 15, 1995, the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) opened Project Heartland, America's first community mental health programme specifically designed to intervene in the short to medium term with the survivors of a major terrorist event. The Project was established with funding from the Federal Emergency Management Agency (FEMA) through the Centre for Mental Health Services. Its design, implementation, and management were solely a local effort, although federal guidelines dictated service priorities. Despite the lack of a pre-disaster plan or interagency service agreements, the work began.

The goal of Project Heartland was to provide crisis counselling, support groups, outreach, and education for individuals affected by the bombing. In May 1995 ODMHSAS sponsored a state-wide forum in Oklahoma City to obtain community input in the development of service goals for the mental health recovery plan. Call & Pfefferbaum (1999) suggest that the use of this form of quasi-public disaster relief planning workshop appeared unique in the disaster literature at the time. One-hundred stakeholders were invited to participate in one of five half-day facilitated workshops to develop specific mental health goals for disaster recovery. They report that the stakeholders made 15 primary recommendations to help ensure that the agencies involved in Project Heartland would enlist qualified providers and use a multi-disciplinary team approach to deliver accessible, high-quality, culturally sensitive services to a variety of special populations affected by the bombing. Thus during the first two years staff were creative and flexible in researching, designing, and implementing services for survivors, family members and the community.

Project Heartland was located in a two-storey multi-tenant office building in Oklahoma City. The project was initially staffed with 22 individuals, including a director, professional counsellors, outreach workers, and support personnel. Contracts were signed with eight partners - both state and private organisations - to extend services to predefined populations, including ethnic minorities, persons with pre-existing emotional disorders, elderly persons, and children. In this context it was felt that ‘this blend of state and private groups is both unique and highly desirable because it offers accessible services by experienced professionals and integrates post-disaster services with existing programmes’ (Call & Pfefferbaum 1999).

During the first two years the Project provided support services, (including support groups, client advocacy services and a telephone helpline), education and training, system support, and treatment team meetings. Following these services in number of hours were outreach services, which included door-to-door visits and mailings; emergency services and crisis intervention; counselling and therapy; and screening, evaluation, and referral services.

The maximum impact of outreach efforts occurred in the first 12 months. Outreach was accomplished in several ways. The outreach staff visited every home and business within a mile radius of the blast. Home visits were also made to survivors, victim's families, and rescue workers. They stationed staff at the FEMA disaster centre and the American Red Cross Centre as long as those facilities were open. They attended meetings and reunions of survivor groups. Reflecting on the lessons**,** Call and Pfefferbaum (1999) stated that it would have been preferable to have more outreach staff for a shorter period of time, especially during the first six months. They recommended that outreach training be included in pre-disaster planning efforts.

Services continued to be provided after the first two years although the programme was reduced in size and focus. Ongoing reflection and review of the Project's aims and purpose was important. Call & Pfefferbaum comment that staff continued to study the literature, consulted with experienced colleagues, and routinely examined the programme's mission and goals.

Alongside Project Heartland it was recognised that there was a need for an umbrella group that would pool information and help coordinate funding for victim services. Approximately 20 agencies convened in May 1995. Known as the Resource Coordination Committee and the Unmet Needs Committee, this forum quickly grew to encompass 80 agencies. Representatives met weekly to determine and help fill unmet victim needs stemming from the bombing. This group focused on filling service gaps (many services concerned financial and leave benefits and the many needs created by the bombing that insurance did not cover). It was still meeting five years later to review requests from victims, survivors, family members, and disaster workers and allocate a decreasing supply of funds (Office for Victims of Crime, 2000).

2) Dunblane Support Centre

On March 13 1996 a gunman entered a primary school in Dunblane, Scotland and opened fire killing sixteen children, aged five, and their teacher. Thirteen others, including three teachers, sustained gunshot wounds, but survived.

As part of its longer terms recovery strategy, and following the experiences of other authorities, (including those who had dealt with the Bradford, Lockerbie, and Piper Alpha disasters), Stirling Council established the Dunblane Support Centre in a specially erected building located in central Dunblane. The rationale was as follows: 'The weight of evidence supported the hypothesis that those who receive appropriate social and psychological support at an early stage following on from trauma make a quicker and more compete recovery, and that an outreach team, providing a focus for service provision for a limited time, can be a method of effective intervention' (Stirling Council p22).

Following on from a 24/7 drop in centre (set up in a community building for the first several weeks), the Support Centre work was aimed at anyone affected by the tragedy and its aftermath. It was guided by the principle that individuals within the community should define the direction of the response and that the services should be flexible and capable of responding to various needs within the community. 'There has been a commitment to encourage the potential within the community for self-healing, to community development rather than rescue models. There has been emphasis, too, on empowering groups by providing information and support, on enabling and supporting, and on promoting self-determination' (Stirling Council, p22). The main areas of work were communication, liaison and networking, and the provision of practical and therapeutic support (with individuals, families and groups).

Between October 1997 and October 1998 the number of monthly visits averaged approximately 175, some months peaking more than others. (ibid p26). In autumn 1997 a consultation process with

users, families and representatives of other agencies and services was initiated. Respondents were asked to rate their views on how well the Centre achieved its aims of being accessible, providing information, avoiding the trappings of bureaucracy, helping people identify their needs and responding to the them, offering choice in the seeking of help, ensuring confidentiality, and publicising the Centre's services. 'Analysis of the data reveals a consistent satisfaction with the services which were provided. Respondents were also asked to rate the most important features of future services: agreement centred on services which are accessible, which respond to individuals needs, and which ensure confidentiality' (Stirling Council p26).

3) September 11: Family Assistance Centres & Federal Support Programmes

On September 11 2001 a coordinated series of terrorist attacks occurred in the United States, predominantly targeting civilians. Four commercial passenger jet airliners were hijacked and crashed killing almost 3000 people at multiple sites in New York, Washington and Pennsylvania. This was the largest scale domestic terrorist event in US history. Thousands of people witnessed and were traumatised by the events they saw in front of their eyes or on television. The extensive ripple effects of this disaster were felt not only in directly affected communities but nationally and globally. Although citizens from many countries were affected, the examples below relate to centrally coordinated family assistance centres specifically provided in New York, New Jersey and Washington. Even just focussing on these specific impact areas, the huge scale and demands on coordinated support efforts becomes apparent in examining the nature of humanitarian assistance provided.

Following the attacks, in New York on the evening of September 11, responders faced the difficult challenge of planning for psycho-social support without any clear indication of the scale of the impact or demands of the aftermath. Over 20,000 body bags had been ordered, many thousands were seeking information about missing friends and family and there was no pre-designated facility to function as an information or assistance centre. The first family assistance centre was opened less than 24 hours after the attacks. It quickly became a focal point for the gathering crowds of people seeking news of missing loved ones and other support. The location of the official centre changed several times in the first few days as larger and more appropriate facilities were found to cater for the thousands who turned up to attend there. These were political as well as logistical decision making processes and, as with the other case studies discussed, ownership and 'turf' issues had to be managed. In addition, those managing the response were inundated with tens of thousands of convergent volunteers.

By the seventh day a most fitting facility in terms of scale, accessibility and appropriateness was found at Pier 94 – a large exhibits area which, once identified, was very quickly converted into a multi-functional, comfortable and tailor-made venue. Over the following months this became a central resource near to Ground Zero serving many bereaved families and others affected by the disaster. It was not only a place for collecting information but also a one-stop shop for dispensing the full range of information and advisory services required to respond to emerging needs; these included processes relating to identification, financial and welfare assistance and counselling. The centre stayed open 7 days a week and was staffed by representatives from a wide range of organisations from across New York City as well as state and federal agencies.

A couple of months after the disaster services were split, separating out those functions provided on the one hand specifically for bereaved families and on the other for those people more broadly impacted, for example those who had lost jobs, livelihood and homes. The Disaster Assistance Service Centre focussed on a range of human services including income support, food stamps, medical assistance, case management, and job placement. Such decisions to split services again had political ramifications and caused some conflict, highlighting again the sorts of challenges faced by

those managing a longer term and large scale response. After three months, at Christmas, the FAC at the Pier was closed. A ceremony involving families was conducted to mark the symbolic meaning of this significant event. From January those requiring ongoing assistance were serviced at a smaller centre which operated during normal business hours.

Meanwhile at New Jersey, just close to New York, another Family Assistance Centre was set up at Liberty State Park. Services there were delivered by human service organisations- local clinicians and specialists working with volunteer and professional disaster relief agencies - who staffed the centre. Disaster responders from the National Organisation for Victims Assistance (NOVA); the American Red Cross; the Salvation Army; the Federal Emergency Management Agency (FEMA); and other volunteer relief agencies, provided on-site crisis counselling and support services every day.

Many families from New Jersey visited this Centre to seek social, financial and emotional support, and many elected to go by ferry from Liberty Park to Ground Zero, escorted by support teams. Simultaneously, crisis counselling, disaster stress education and referral services were being provided in those communities most impacted by the disaster by community mental health service providers.

A third Family Assistance Centre was set up at the Pentagon for victims and survivors of the victims of the terrorist attack there. Again it functioned as a one-stop centre and was staffed by representatives from Social Security, Veterans Administration, the military, Office of Personnel Management, and other federal agencies.

As well as these assistance centres, 9/11 sharply raised awareness that it would be necessary to increase local capacity for community-based outreach interventions. Project Liberty (in New York State) and Project Phoenix (in New Jersey) are two examples of federally funded programmes initiated in the aftermath of 9/11 to alleviate longer term psychological distress by providing supportive crisis counselling to individuals and groups affected by the disaster. These funded programmes continued for a number of years after the disaster in recognition of the need for governmentally funded strategies to support longer term recovery from the devastating impacts of these events and their aftermath

4) The Tsunami Support Network – Including a Virtual Approach

On December 26 2004 an underwater earthquake triggered a series of devastating tsunamis that spread throughout the Indian Ocean, killing over 200,000 people and inundating coastal communities across South and Southeast Asia. A year later 149 British citizens were confirmed to have died, though six remained unidentified and one further person remained missing and highly likely to have been killed in the disaster.

After responding to the initial impact the Foreign and Commonwealth Office asked the British Red Cross Society for assistance in establishing a family/peer support network to meet the medium and longer term needs of individuals affected. Consequently this government department, and subsequently the Department for Culture, Media & Sport, funded a programme of work to establish, develop, manage and facilitate a Tsunami Support Network. In coordinating the Network the British Red Cross was supported by a multi-agency steering group consisting of representatives from organisations such as the Foreign & Commonwealth Office, Disaster Action, the police, the National Health Service, the Association of Directors of Social Services, the voluntary sector, the UK Trauma Group, the Civil Contingencies Secretariat and the Local Government Association. Over the following year the Network activities included the establishment and maintenance of a website, newsletters, telephone support and the facilitation of self-help support groups.

The virtual element of the Network consisted of a website established and maintained by the British Red Cross. The purpose of the website was to help meet the overall aims of the Network, namely to enable people affected by the disaster to obtain information, benefit from peer support, share common experiences, guidance and advice and address issues arising from the disaster. To this end the website included details of useful information and news, a range of support services, copies of newsletters, press releases and other news items, a moderated discussion forum and links to other organisations.

There were both advantages and disadvantages in using a website as a focal point. On the positive side, it was a facility that could be accessed from anywhere in the country, and indeed the world, which was especially useful given the global impact of this disaster. Drawbacks included the fact that not everyone is IT-literate; thus any detail disseminated this way was, where possible, also disseminated using more traditional communication methods. A further challenge throughout the operation of the Network was identifying and reaching the target population; indeed, like many of the case studies here, it was never possible to quantify in any detail or depth the true number of those affected by the disaster and potentially in need of services and support.

The Network's website was one form of outreach following the Tsunami. It was complemented by other centrally-run efforts including a nationally coordinated family liaison service (for liaising with bereaved families) and, after the initial phase, a strategic multi-agency coordinating group chaired by the DCMS at the Cabinet Office. Lessons learned included the need to develop further protocols for the sharing of information following a large scale event, especially given the significance of confidentiality and data protection issues.

The British Red Cross's response to the tsunami also highlighted the importance of responding early and proactively to people's keen wish to be in touch with others affected by the disaster. This did not need to be through formal meetings and eventually occurred through large and smaller group gatherings, some facilitated and some not. By the time of the first anniversary a committee made up of members of the Network, i.e. those directly affected by the disaster, had started to organise plans for future events and the formalisation of their own support group. This marked the transition towards the effective exit for the British Red Cross which had, from the start, intended to hand over responsibility for the administration and direction of the Network to members themselves at the appropriate time.

Lessons Learned: Benefits of One-Stop Shop Approaches

A number of common themes and key lessons have emerged from these and other one-stop shop approaches over the last twenty years or so. The evidence suggests that the benefits of planning for and providing one-stop shop approaches may outweigh the costs. In particular the benefits of one-stop shop approaches (for users and providers) include the following:-

1) They offer convenience to users by having a range of services available in one location or via a single gateway as opposed to their having to trawl through many and complex organisational and bureaucratic hurdles in order to access support.

2) They can function as a centralised and authoritative source of information. The Emergency Planning Society (1998) promotes the value of such a single information point for the giving, receiving and coordination of information for all involved (1998:24).

3) Where effectively managed and coordinated, communication to staff as well as users can be effectively disseminated and updated on a regular basis. Experience has shown that this depends on good management and administration 'Staff meetings should be held and daily

briefings should be provided to facilitate staff communication and provide updates on the status of the emergency situation' (Bune 2003a).

4) Centralised provision offers better opportunity for those from support and other agencies to be in contact and thus able to work more closely and collaboratively in providing a seamless approach to service users. (Discussing the key collective lessons from providers of support services in the 1980s, Allen (1991) states: 'Support workers have stressed the need to have a range of services available, and to have close contact among those providing the services').

5) The immediate needs of users may be met more quickly and efficiently by implementing pre-planned and pre-tested facilities that are set up speedily and in a coordinated manner: 'This support requires the coordination of the police, health services, social work services, education, voluntary and religious organisations' (Allen 1991:7).

6) A one-stop shop approach may prevent unhelpful overlap and duplication of services and hence a waste of resources and efforts. At the same time it may be important to offer users a choice in the nature and range of services available where appropriate.

7) A centralised facility may better enable deployed staff to be wholly dedicated to their disaster response roles and hence potentially more effective/less distracted but other demands. (Though evidence suggests that if management and support of a dedicated team is poor, this can impact on the welfare of team members (Newburn 1996)). While weighing up these benefits, there may be a potential cost to organisations in terms of bad feeling if other staffs have to cover disaster responders' routine work without sufficient recognition or reward. On the other hand, failing to cover responders' routine work at all may have consequent effects on *their* stress levels once they return to 'normal' duties after deployment. Recognition of all these factors through planning and management support is crucial here.

8) There are advantages in disaster responders feeling part of a collective team rather than conducting work at disparate locations without team spirit and support (after Piper Alpha, for example, some of the part time disaster workers remained in normal teams at a geographical distance from the centre of Aberdeen while maintaining also their usual case load. The manager attempted to address their potential isolation by ensuring they felt part of a team (Bone 1996 27-8)).

9) Coordinated and effective proactive approach early on means longer term outreach and referral efforts may have greater success. (Kaul (2002) states that this was a key lesson and benefit from community mental health-based organisations collaborating through joint meetings in Washington after the Pentagon attack).

10) It has been argued that planning for and running assistance centres makes good business as well as moral sense after disaster. 'The cruise lines, rail, and to some degree highway, have seen the effectiveness of the plan, which requires communities, industry, non-profits, state and local governments, to come together to provide assistance to victims' families. And many of them have recognised that assisting people in the aftermath of the disaster is not just the right thing to do, but it makes good business sense as well' (Sharon Bryson, Director NTSB Office of Transportation, Disaster Assistance, cited in NTSB 2006:5).

Addressing Potential Flaws

Despite these benefits, it is important to justify the potential costs, financial and otherwise, of investing in planning and responding to the psycho-social impacts oaf disasters through, for example, such assistance centres and other longer term coordinated recovery strategies. It is suggested here that the potential costs of providing one-stop shop assistance (as opposed to providing nothing at all or investing in efforts that are completely uncoordinated) can be transformed into benefits through careful pre-planning alongside effective and organisation and management in the event of a response. By way of illustration, some of the potential flaws are as follows:-

1) An inappropriate service – This might occur if an overly prescriptive, 'tick-box 'or top down model is imposed on a community or in response to an incident without careful consideration and regard for event-related appropriateness and the grass roots needs of potential users. Involving the community in planning and longer term recovery strategies may mitigate this. An example of where this happened well is in the Washington area after the Pentagon attacks of 2001 where a key strategy of the multi-agency community mental health initiative was to facilitate the transition of its group's leadership to community participants. (Kaul 2002).

2) Over-dependence on users making the move to come to a facility would be a fundamental flaw. Rather, any central provision should be accompanied by an active outreach strategy enabling services also to be taken out into the community as and where appropriate. Outreach to particular schools or workplaces for example might be necessary after any particular event. Following the September 11 attacks, a key feature of the federally funded programmes was the provision for services to be taken out in the community and adapted for use by and with users where they were based.

3) An inaccessible service – An example of this would be a focal point for a physical response that is far from potential users and thus physically and culturally inaccessible to those it seeks to serve. Given that many events have a ripple effect extending beyond any one physical location, it may be desirable to consider satellite centres and proactive outreach (e.g. through home and away teams) as part of a comprehensive strategy in the interpretation of one-stop shop support.

4) Failing to meet the needs of particular users - Overlooking the needs of the injured and others who cannot access a one-stop shop is a potential hazard. Establishing a parallel system for the injured is critically important so as not to overlook or marginalise them and/or their families (amongst others, Bune 2003a highlights this as a key lesson from September 11). Relying only on virtual technology or other methods that may be inaccessible by potential users is also a potential flaw. Sole dependence on the internet, for example, discriminates against those who are not IT literate. Similarly facilities such as a helpline should include provision for the deaf or hard of hearing who are unable to use the telephone. These challenges can be addressed by ensuring that a range of methods is used for reaching target populations.

5) Unintended messages – An unintentional consequence of identifying a central location with the disaster can be that those outside the immediate impact zone are given the impression that support is unavailable to or unintended for them. (For example after Hillsborough, although a federal structure was set up that reached out to several key affected areas, the structure still unintentionally served to reinforce the view that they were the *only* regions affected. Many outside these regions were not offered a service). Marketing and

communications strategies may be key to addressing this alongside other strategies such as satellite teams. 'Unless specific measures are taken to set up an 'away' team as was done after the Piper Alpha and Herald disasters, it is likely that large numbers of those affected but who live outside the main areas will 'fall through the net'…local authorities that have few bereaved or only survivors in their area will tend to perceive themselves to be largely unaffected and will do little in response' (Newburn 1996a:17).

6) Identifying a focal point may led to convergence. Having to address and mange convergence at a centrally identified focal point was a challenge after publicity about the assistance centres for 9/11. Convergence included approaches by untrained and unscreened volunteers as well as the media. Having a strategy for staffing, clear identification of roles and responsibilities and a pre-planned media policy may help to address this. Developing a policy concerning donations and gift processing as well as a procedure for volunteer screening was a lesson learned for assistance centre planning after September 11 (Bune 2003a and Herrmann 2006). In terms of media intrusion, having a clear strategy for coordinating media requests and providing information to the media has been found to be productive. Bune highlights the valuable role of Public Information Officers in this regard (Bune 2003a).

7) Costs of taking staff away from their 'day job' - Deploying staff at a specialist centre may takes staff away from their usual roles and routines with knock on effects for colleagues and those dependent on their usual services. There may also be potential for burnout through over-exposing staff if they are insufficiently prepared, trained, briefed or supervised for a specialist role at an assistance centre. Pre-planning and training as well as good management and supervision (both on site and back at the usual workplace of those on disaster teams) is essential to address these potential costs. Making available separate and private welfare and eating facilities for staff is also imperative in this respect.

8) Potential for political infighting and competition among or between agencies or individuals responding. Tension – or 'turf issues' - among individuals and organizations involved in disaster response at centralised locations is not unusual as many post-disaster accounts testify (e.g. Call and Pfefferbaum (1999) and Stirling Council (undated)). This can to some extent be reduced by pre-planning and networking before disaster strikes. From their experience, Call and Pfefferbaum recommend that those specially trained staff involved in response 'should work closely with other agencies in pre-disaster planning and … should be knowledgeable about the various organizations involved in the response. This staff needs clear governmental authority to direct service delivery'. Based on the experiences of family assistance centres after 9/11, Bune (2003a) agrees, recommending there be a clear chain of command in place with a senior person in charge and on the scene at all times with the authority and power to provide directing and take action.

9) Insufficient attention to closure issues from the start. This can lead to insufficient political and economic support in the longer term and a lack of clarity affecting funding for ongoing provision. At worst it may lead to promises and commitments that are not able to be followed through. Counteracting this can be achieved by having clear, stated and widely shared initial aims and purposes for any programme. This should include planning for and discussing the meaning and implications of an exit strategy on an ongoing basis and reviewing aims and goals at regular periods throughout the project. Long term strategic decisions should be taken in the early weeks – for example, what sort of team will be set up and how long it will operate for – and should be adhered to (Newburn 1996a).

10) Insufficient planning for longer term staffing issues leading to poor organisation and staffing problems. Newburn (1996a:17) suggests that the stresses experienced by staff can easily be exacerbated by organisational problems affecting the work, including a lack of clarity regarding the length of an operation and commitment to a project. Crucially, although some flexibility is necessary, workers need some indication of how long the service will be maintained and that the work is supported and valued by their department. Otherwise failure to provide a secure environment for the work is likely to undermine the extent to which staff feel they can work effectively.

Best Practice Guidelines

The case studies reviewed here demonstrate how common features of humanitarian provision after disaster have evolved over time. Some key principles have been incorporated in different models of psycho-social support which have varied on the basis of factors such as context, type of event and funding sources/support. 'Best practice' seems to have developed on the basis of a 'lessons learned' approach that draws on the experiences of service providers and in some cases, though to a limited degree, user evaluation. Notwithstanding the lack of more scientific or systematic approaches to programme evaluation, the following are key pointers for those considering future models.

- In keeping with the requirements of the Civil Contingencies Act and other guidance document within this field, humanitarian assistance planning should be integrated into preparedness, training and exercising activities across sectors and from local, through to regional and national levels of response.

- As well as short term impacts, joint planning, preparedness and training should focus specifically on addressing medium and longer term elements of disaster recovery within and across disaster-impacted communities.

- Planning and response will benefit from including consideration of one-stop shop approaches. The scale of needs arising from a catastrophic event is likely to involve multiple sites and may necessitate multiple assistance centres and support teams.

- A flexible and appropriate (as opposed to an over-prescriptive and imposed) approach is important and proactive outreach and communication strategies should be included.

- Providers should be prepared to address the challenge of planning for psycho-social support without any clear indication at the outset of the scale of the impact or demands of the aftermath.

- Models should reflect principles of community resilience and support processes of self-healing. They should draw on the potential for individuals and communities to participate in determining their own strategies for recovery and development.

- Providers should ensure programmes are fully accessible (e.g. physically, culturally and economically) by target populations, including special populations.

- There can be advantages to obtaining community input and participation in the development of service goals and design of recovery strategies and programme content.

- Only carefully screened and qualified providers should be enlisted and both specialist and multidisciplinary teams may be necessary to deliver high-quality, culturally sensitive services. Where appropriately trained and available, local grass roots community based agencies will significantly increase reach into the community.

- Providers should be prepared to work within a potentially conflictual environment where political decision making processes, ownership and 'turf' issues abound.

- Strategic decision-makers should be prepared to be creative and flexible in researching, designing, and implementing services. At the same time they should be critically reflective in addressing the unique challenges of each disaster. Most provision after disaster has, by necessity, needed to include some element of innovative thinking and action.

- It is likely that the maximum impact of outreach efforts will be in the initial stages, e.g. the first 12 months. Services may be needed for longer but are likely to be reduced in size and focus over time. Caution should be exercised in basing decisions on time-scales alone or equating need, legitimacy, value or the effectiveness of provision simply with the number of users. Attention to exit strategies from the outset and regular programme review is crucial.

- Service reviews should include user evaluation, dissemination of lessons learned and suggestions for future planners/providers.

Key Points

- The development of service provision over the last twenty years or so has reflected better understanding of the nature of the psycho-social effects of disasters and the need to plan for a coordinated approach to emergency planning and response.

- The evolution towards this centralised and coordinated approach to support has included the development of one-stop shop approaches. In practice there are various ways in which this concept has been applied.

- Some common themes and key lessons have emerged from experiences of setting up longer term assistance programmes. These highlight the benefits of one-stop shop and other approaches and how potential flaws may be overcome.

Further Reading

Cabinet Office/ACPO (2006) Humanitarian Assistance in Emergencies: Guidance on Establishing Family Assistance Centres (http://www.ukresilience.info/publications/facacpoguidance.pdf)

Disasters Working Party (1991) Disasters: Planning for a Caring Response HMSO London

McLean I & Johnes M(2000)Aberfan: Government and Disasters, Ashley Drake Publishing Ltd, Cardiff

Office for Victims of Crime (2000) Responding to Terrorism Victims: Oklahoma City and Beyond, U.S. Department of Justice, Washington

Part V: Looking Forward: Planning for Humanitarian Response

The evidence reviewed thus far reinforces the key message that organisations should prepare a comprehensive plan for meeting the psycho-social needs of those affected by disaster. As well as those Category One and Two organisations covered by the Civil Contingencies Act, other organisations which may have a role to play in responding to disasters affecting their staff, clients or wider publics should actively engage in these planning processes. This includes, but is not exclusive to, for example: the emergency services and emergency planning departments, those involved in health, social, psychological and community based welfare services, regulatory bodies, voluntary organisations with an interest and role in civil protection (including faith based organisations) and organisations providing death and bereavement related services. Any organisation covered by health and safety legislation should recognise that psycho-social health and wellbeing includes a major incident of disaster context; in other words, the requirement to plan is broad rather than limited to those specialising in emergency planning and disaster management.

What is perhaps more significant in considering today's level of planning and preparedness is not so much the evidence about the need to plan but rather the failure by some agencies to recognise and respond to that need. Although reports such as that of the Disasters Working Party (1991) recommended proactive psycho-social planning and training, it has more taken the legal duties brought about by the passing of the Civil Contingencies Act (2004) to reinforce and start to drive through the impetus for action in many quarters.

Common Pitfalls in Psycho-Social Planning and Response

Research has highlighted some potential failures in the area of emergency planning and practice. Common pitfalls in psycho-social planning and response are summarised below with reference to the implications for good practice to overcome such weaknesses.

1) Looking for a product rather than engaging in processes

This is a major planning weakness which has long been identified by researchers examining the work of emergency planning officials and their plans (Drabek 1986:53). Wenger, James and Faupel (1985) conducted an in-depth review of these and recommended that future planners should address the fact that 'there is a tendency on the part of officials to see disaster planning as a product, not a process' (1985:156).

Furthermore, approaches to rescue may focus too much on processes rather than the victims they seek to serve. Activities which promote the ongoing revisiting, updating and participation of stakeholders with plans may mitigate this weakness. Reference to the psycho-social elements and impacts of processes should also be specifically included.

2) Failure to provide a truly coordinated and integrated approach

Research and experience has shown that much disaster planning does not adequately deal with the problem of inter-organisational coordination at the time of a community emergency. This applies both in general terms and in relation to psycho-social planning and responses. Those who have responded to disasters affecting individuals and communities across local, regional or national boundaries have commented on the challenges faced in seeking to plan and implement consistent services (e.g. Whitham (1996); Henwood (2005:3)). This includes problems being exacerbated when arrangements for disseminating emergency information to all crisis relevant organisations, mass media sources and the general public have been missing from disaster plans.

Awareness of interagency issues and cross boundary approaches is necessary at both the planning and response stages and attention to these should be backed up by robust communication strategies and strategic response plans. An approach which uses regional or national coordinating groups may help address the potential problems relating to a coordinated and integrated approach, though it is important that communication and provision are not weakened by such a centralised approach.

Reinforcing the analysis discussed earlier, integration here also means addressing the needs of all those who may be vulnerable to the impacts of disaster. 'It must be remembered that disaster can affect people of all ages, all ethnic backgrounds, and all social classes…Just as disasters are unique, so are the reactions of the people affected by them' (Gibson 1994:144)

3) Adopting a short term approach which does not sufficiently address longer term impacts and needs

Studies have historically found that very few disaster plans take into account the transition from the emergency period to the recovery period and very often fail to deal with the inevitable movement to normalcy (Drabek 1986). This becomes particularly significant in considering humanitarian assistance planning and response since psychological and social effects of disaster are known to continue long after the immediate impact and response phase. Exercises often fail to include decision-making and activities which take place after the immediate emergency period or after the first few days of an incident are over. As discussed, this is when the disaster is only just beginning for many people directly affected.

A review of plans, training and experience would address this with particular reference to timelines and the extent to which they detail and rehearse events and actions associated with the medium to longer term phases of disaster are actively considered. Also, as discussed earlier, the development of any response-based strategy should consider and be clear about the importance of balancing exit strategies with providing appropriate longer term support.

4) Lack of local buy-in and political support

Political support for psycho-social planning at local and national level can be particularly important for the success of humanitarian planning and response initiatives. Whitham reports how coordinated responses after Kegworth and Hillsborough would have been difficult to achieve without the support of elected members (county and district councillors and members of parliament among others): 'Their role in providing recognition of the importance of this work and in clearing some of the bureaucracy and accessing resources needs to be recognised and is another vital issue in planning a disaster response. Despite the enormity of the tasks facing those local authorities, this collective approach did go a long way towards managing consistent approaches and sharing lessons learnt. It is a model I would recommend' (Whitham 1996 NISW 38). While the Disasters Working Party (1991) welcomed the recognition by the government of the day that local authorities are best placed to manage the aftermath of a disaster, it expressed concern at the lack of statutory duty supporting this. Since then of course, this recognition has been formalised through the Civil Contingencies Act (2004).

Local buy-in and political support might thus be improved through the active liaison between local and regional resilience forums and other initiatives generated by the Act. It is important however that local political leaders and Category One responders actively engage all relevant political stakeholders in planning, funding and support strategies.

5) Fragmented approaches to support based on either a 'medical treatment' or 'social service delivery' model

An observation made some thirty years ago continues to be relevant to psycho-social planning today. In 1980 Baisden and Quarantelli (1981:197) commented on the existence of two competing models on the organisation of mental health services in disaster, namely a 'medical treatment' model and a 'social service' delivery model. They stated that over-reliance on one or other approach can lead to a fragmented or uncoordinated approach to service provision. These diverse approaches persist today in relation, on the one hand, to health-based, psychological (particularly trauma-based) approaches to disaster research, planning and provision and, on the other, to social or community-based approaches.

Service users are unlikely to make such a distinction in relation to their needs but may find they are falling through gaps when their needs do not fit into existing institutional or bureaucratically organised services. This was certainly the case with some people seeking help after the tsunami. Additionally, over-reliance on a mental health based approach may over-medicalise, pathologise and stigmatise reactions (see below) while insufficient understanding of and attention to trauma related impacts may mean opportunities for timely necessary interventions are missed.

The two approaches and the problems they engender persist in part because they are institutionalised within either the health (primary care and mental health) or social (adult and children's services and other aspects of social care) sectors. Consequently within a local area there may well be both a psychological response plan, (headed up by a *psychologically-based* coordinating group and engaging the services of, for example, educational psychologists, psychiatrists and other mental health specialists), and a *social or community based* response plan (often linked with the emergency planning officer in consultation with local authority social services staff or crisis response team, including voluntary sector support, and focussing on practical and emotional support in rest centres etc). The extent to which these two sectorised plans and responders are integrated is likely to vary in different areas with impacts therefore on the degree of coordination and integration in meeting needs after disaster. This should be monitored and addressed at the planning stage.

As stated earlier, Hodgkinson and Stewart commented as far back as ten years ago on the institutional divides between health and local authorities and the negative consequences of this for dealing with disasters in the 1980s. Acknowledging this, the Disasters Working Party commented that as well as focussing on local authorities' roles, it had written separately to the Department of Health emphasising the importance of providing an adequate level of resources for the social and psychological support elements of emergency planning (1991:9).

A user-based approach to understanding the needs of those affected by disasters challenges such a fragmented approach based on the two models. Considering needs from the grass roots perspective is more likely to encourage a holistic understanding of the humanitarian impact and effects of disasters rather than from an institutional, top-down approach; this perspective should therefore be incorporated into planning, training and responses and institutional barriers should be challenged and addressed wherever they arise.

6) Poor uptake due to perceptions of services and their appropriateness

Poor uptake may result if services on offer are delayed, poorly communicated, inappropriately 'badged' or are culturally inappropriate for the community they seek to serve. Researchers and practitioners have long emphasised the important of a proactive outreach approach to community support services which address these factors (Disasters Working Party 1991; Hodgkinson and Stewart 1996; DeWolfe 2000). The preventative effects of early - rather than delayed - interventions have been recognised in relation to mitigating negative practical and psychological consequences. DeWolfe comments that 'outreach approaches that offer practical assistance with problem-solving

and accessing resources are key to a successful programme….programmes should establish a vital presence early in recovery, developing creative strategies to meet survivors where they are and bring them forward in their recovery process (2006).

A culturally appropriate service is one that takes account of and is flexible enough to engage with a diverse range of individual survivors and the varied elements within any community. When outreach efforts actively "fit" the community being served, survivors' access to assistance is enhanced. Focussing on disaster mental health services in particular, DeWolfe highlights some salient dimensions for consideration: 'ethnic and cultural groups represented, languages spoken, rural or urban locales, values about giving and receiving help, and who and what the affected groups are most likely to trust. Access and acceptance is gained more quickly when disaster mental health programmes coordinate and collaborate with local trusted organisations' (DeWolfe 2000:6).

Acknowledging and addressing potential personal or institutional barriers to uptake helps potential users access support. In relation to psycho-social support, a common barrier rests on the fact that most people do not see themselves as needing mental health services following a disaster and will not seek such services. In addition to this community stereotypes relative to the concepts of mental health and mental illness often influence the success of a disaster invention programme (Drabek 1986:53, McLean and Johnes 2000; DeWolfe 2000:5). After the Hillsborough Disaster (1989) a stoic acceptance and strong beliefs about being able to cope, combined with the stigma associated with accepting professional help, needed to be addressed: 'The five major barriers to accepting or requesting help – recognition, acceptance, worthiness, information, stigma – have important implications for the organisation and running of a post-disaster service. Self-evidently, given the above, services need to reach out to those affected by the disaster. The majority will not seek help without being prompted' (Newburn 1996a:19).

An important part of training for those providing psycho-social support is explaining that victims should not be perceived as, labelled or treated as mentally ill on account of their disaster experience. Rather, as stated earlier, approaches to working with those affected by disaster should be resilience-based and aimed at facilitating self-help processes rather than patronising users. In fact most assistance labelled as mental health is often more practical than psychological in nature (DeWolfe 2000:5). The frequent media references to 'counsellors' being on site in the aftermath of disasters are often both inaccurate and less than helpful in this respect, a factor which highlights the importance of a good communication strategy and media relations to get across the exact nature of what is on offer and by whom.

7) Failure to identify and reach those who may benefit from the service

Even where a psycho-social service is designed to be inclusive and appropriate it may fail to reach to those in need. Despite a robust communication strategy being in place, opportunities to disseminate information may be thwarted. After the London bombings (2005), for example, attempts by those running the Family Assistance Centre to use the media to publicise its services were limited because of the media's greater interest in focussing on the terrorist attacks themselves and the perpetrators. After the 2004 Tsunami, too, in part because of the nature of the disaster and where it happened, targeting outreach communication was problematic because it was very difficult from the start to estimate how many people were likely to have been affected and where/how best to reach them. It took many weeks to identify those likely to be bereaved, but identifying all those who were survivors and who may have benefited from support was never going to be possible. In developing a communication strategy to disseminate details of support groups and other meetings, organisers of the British Red Cross Tsunami Support Network felt that it was necessary to reach a balance in reaching out as widely as possible while at the same time trying to ensure that only those most needing certain information received it. The concern was not to encourage inappropriate take

up of service and intrusion in private family meetings and support groups by, for example, media reporters or those with no actual involvement in the disaster, as has happened after previous disasters.

The development of police family liaison officers has been helpful as a conduit to and from bereaved families once it has been possible to establish those most likely to have been killed. However, this cannot be relied on as not all families will necessarily take up or retain the offer of a FLO. Furthermore, this does not cover survivors who are, as highlighted with the tsunami, much harder to trace. After disasters like Hillsborough, too, offering a service to survivors was found to be somewhat more problematic. This was borne out by Newburn's research which found that only about 10% of survivors appeared to have been in contact with social services. He commented:

'There are a number of lessons from this. Firstly, it confirms the importance of having a 24 hour, seven days a week helpline as the major back-up to a proactive counselling service. Secondly, it suggests that those responsible for the organisation, management and provision of services after disaster need to review how such services are brought to people's attention. Hillsborough workers were generally of the view that much more 'outreach' work could have been undertaken, for example in schools and places of employment – two sites where considerable resistance was often encountered' (1996a:20).

A key point of contact for identifying those requiring help after disaster and reaching them is general practitioners. Newburn reflects the comments of many bereaved and survivors from both historical and recent events when he states that this is one particular area where help might have been expected to have been forthcoming. However, after Hillsborough although a small number of respondents mentioned having positive support from their GP, this did not appear to have been the case in the vast majority of cases and, indeed, was mentioned as having been particularly unhelpful by some. Anecdotal evidence suggests this has been the case for those approaching their GPs after the tsunami and London bombing also. It thus seems that Newburn's conclusions from ten years ago remain as relevant today: 'Considerable efforts need to be made to make GPs more aware of the impact of stressful events such as disasters, and to encourage them to consider referring patients to social services or other organisations rather than replying on medical intervention alone' (1996a:20)

8) Evaluating a service on quantitative measures alone, such as the number of people taking up services

The pressure to legitimise provision based on the number of people taking up its services and the proportion or percentage of a community designated 'affected' is understandable given the need to justify financial and other outlays in setting up and running support services. However given the points above it is important for providers and funders to understand that lack of extensive take up does not mean *either* that a service is ineffective *or* that there are unmet needs within the community which can only be met through the services on offer. Service providers and those funding them should expect that most disaster victims will not accept outreach efforts and that this maybe because there are other avenues of healing available rather than because a service in inappropriate, ineffective or unneeded. This reinforces the point that after the initial assistance provided by outreach information and support many people will recover naturally through the natural support of family and friends and without the need for any specialised interventions.

The political and financial implications of planning and providing a service, however, means that financial worth and legitimacy may well be expected to be expressed in quantitative terms. This has long been recognised by disaster researchers, with Baisden and Quarantelli commenting as far back as 1979 that practitioners should be forewarned that once programmes are initiated, pressure to demonstrate legitimacy may deflect from original goals and expectations:

‘When a project .... is funded, particularly with public money, pressure is exerted to justify it by means of a detailed quantitatively documented needs assessment …Outreach can become an effort aimed at attaining a magic number, delivering the types of service committed to, rather than searching out those in need and providing the services required’ (Baisden and Quarantelli 1981:8,9).

Consequently, for example, it was tempting for those running the Tsunami Support Network to regard the success of the Network or the events it organised in terms of the number of people who formally registered or attended a support group meeting. In reality, however, many more people are likely to have accessed the information available through its website than those who formally registered with the Network and remained actively involved. It might even be the case that less active participation of the Network was an indicator of its success, i.e. the sense that as people became stronger and developed their own support strategies they wished for less active involvement through the Network. Without research and evidence that identifies exactly *why* people choose to take up services or not and when, and what difference it makes for those who do or do not take up services, it is difficult to provide a true measure and rationale for the value of a service as the basis for evaluating it. Given the methodological difficulties in gaining such data, the challenge of justifying a service remains a significant one for funders and providers who should be minded of the importance of considering carefully the criteria for evaluation and justifications for levels of financial support.

9) Failure to appreciate the importance of continuity in the planning and provision of support

Addressing continuity is the logical starting point for understanding individual and organisational responses after disaster and should be central to the planning and structuring of psycho-social support. In terms of the meaning of continuity, various studies show that ‘people do not abandon their social histories when confronted with adversity – and organisational systems reflect it’ (Drabek 86:158). One implication of this is that those organisations which are well prepared, organised and resilient before disaster are more likely to reflect similar qualities during and after disaster response. A second example of continuity is the fact that at times of uncertainty (such as in and after disasters), people and organisations function best in relation to those systems and processes with which they are already familiar. Thus where specialist, external and unfamiliar help is brought in after disaster and where psycho-social support does not incorporate or engage with familiar and sustained elements of community-based support, it may be more likely to fail unless sufficient account is taken of the significance of embracing elements of continuity where appropriate.

Studies of emergency planning in general have identified discontinuity as a common flaw: ‘Too often disaster planning is isolated from the day-to-day planning process. It is often assigned to organisations or units within organisations that are divorced from traditional, institutionalised sources of social power within the community’ (Wenger, James and Faupel (1985:156). In relation to psycho-social support the pros and cons of setting up specialist services have been discussed earlier in this review. While disaster-specific services have benefits in terms of being tailored, they may fail to address the importance of continuity. This should be taken account of in deciding which type and forms of psycho-social service best suit any particular disaster response.

Commenting on psycho-social planning in particular, Gibson has stated that it should adhere closely to normal practice and use established communication networks. ‘Plans need to be “owned” by those who will have to enact them. This can be achieved by enlisting their help at the design stage and in the updating process. Good practice is the best insurance that any disaster response will be adequate’ (1994:143).

In managing a longer term response too, the theme of continuity should also be recognised. This applies particularly after the emergency phase when staff turnover is likely to be a factor as normal services resume and staff are redeployed away from the service they have been providing in relation to the disaster. Emphasising that helping agencies should be able to relate to the incident, Gibson emphasises that 'continuity of helper is most desirable' (Gibson 1994:141).

Continuity across services should also be carefully considered as part of a coordinated or 'seamless' approach. Whitham's experiences in Nottinghamshire of discontinuity are relevant today: 'Notions of a 'seamless service' are current in everyone's community care vocabulary. Had we thought of the phrase this would probably have been in our disaster vocabulary too. This very much reflected our wish that services begun at the time of disasters could be continued in the longer term, rather than the response being seen as a short term single agency intervention. It also reflected our frustrations in dealing with other agencies who were not always sympathetic to requests for continuing care of returning victims' (Whitham 1996:41). This is especially important when disaster victims return home after experiencing disaster away from their community, whether in the UK or abroad.

10) Equating experience with expertise and evaluation in providing services and learning lessons

It might be tempting to feel and assume that the intense experience of responding to a disaster qualifies one as an 'expert' not only on that disaster but on disasters in general. This would be a misperception however and caution should be exercised in attempting to either assume such expertise or to generalise from a particular event and its response. Experience of a single or event multiple events should not be equated with expertise, not only because each event is unique, but also because a proper evaluation of expertise should include an independent assessment of the combined qualities of knowledge and demonstrable skills rather than experience alone.

This is important for psycho-social planning and response to disasters because it is sometimes implied that individuals who have previously responded to a disasters, or participated in delivering a particular form of service provision, are necessarily appropriate for deployment subsequently, despite the fact that such assumed expertise remains effectively unvalidated and the quality of the contribution unevaluated. One of the ways in which lessons from disasters are disseminated has been through conference presentations by responders with direct experience of a particular event. This can be valuable in terms of sharing those experiences, but in building up our collective knowledge and dissemination of expert opinion for future planning and response it is important that such perspectives are not regarded as either the whole, or even a necessarily accurate, picture of all aspects of a disaster and aftercare. Where appropriate, it should be noted and stressed that these assessments have not been independently verified and that their opinions may be partial rather than generalisable.

Furthermore efforts towards developing systems for more uniform training and accreditation in disaster response will in future help planners and managers of provision to identify appropriately qualified responders and appropriate experience (interestingly the Urban Dictionary provides a tongue-in-cheek definition of an 'expert' as 'someone who thinks they knew how to do something but actually just screwed everything up' (http://www.urbandictionary.com)).

With this in mind it is also significant that many writers have emphasised the importance of recording and learning lessons from each response in order to allow future plans and response to be refined and enhanced. Gibson (Gibson 1994:133) acknowledges how this enables tragedy to be transformed into opportunity while Whitham observes that hindsight is vital that we learn the lessons of history if we are to plan for the future (1996: 37).

In developing this review, however, the huge variety in the methods, type and depth of evaluations of responses to particular forms of post disaster support has been noted and it is clear that a more systematic and uniform approach to recording lessons and evaluating provision would offer great benefit. In order to build up a bank of expert knowledge it is suggested that protocols for monitoring and evaluating the quality and effectiveness of psycho-social services should be developed and applied as an integral part of disaster response and actively included in pre-disaster planning and funding strategies. More research and discussion is needed to identify and assess the most appropriate and effective forms of such monitoring and evaluation especially given the methodological challenges associated with this area of work. The inclusion of ethical parameters and protocols for a review should also be included in any such endeavour.

Finally, more could be done to develop the scientific basis of our knowledge and understanding by bridging the activities of disaster-related research and practice in relation to the psycho-social dimensions of disaster and their management in the UK. This would be mutually beneficial for researcher and practitioner communities and would support the conclusion of reviewers such as Drabek when he stated 'I remain convinced that the quality of disaster research will be improved immeasurably if the interaction between practitioners and researchers is increased' (1986:416).

International precedents offer useful examples here. A history of research into disaster-related behaviour has been linked with a strong practitioner-focused approach to learning and documenting lessons and expertise in the Disasters Research Centre at the University of Delaware. Lessons from disaster research have also been disseminated through publications such as that of the International Sociological Association's Disasters Research Committee and the Australian Journal of Emergency Management (www.ema.gov.au).

It is suggested here that sources of funding in the UK should be consolidated to promote a more active research culture which could support and promote evidence-based psycho-social planning and response. Funding would enable more research to be conducted and would support meetings between researchers and practitioners. By way of example, funding provided by the National Science Foundation in the USA, has enable the University of Colorado to develop a practical approach to gathering information to inform best practice. Their Natural Hazards Centre Quick Response programme offers social scientists small grants to travel to the site of a disaster soon after it occurs to gather valuable information concerning immediate impact and response. The findings of these studies cover a broad range of disasters - both natural and human-caused - in diverse segments affecting all types of human communities. The findings from this programme often reveal insights that enable scholars to share information with policy makers on mitigation issues or with local emergency management personnel on how response and recovery could occur more efficiently, equitably, and effectively in the post disaster time frame. Frequently, scholars have used the data to develop well-informed research proposals to submit to national funding agencies to carry out more traditional, longer-term hazards research (see http://www.colorado.edu/hazards/qr/).

Part VI: Recommendations for Best Practice

This final part of the review draws together recommendations for best practice based on the key findings and evidence identified throughout this report. Common themes have emerged in the studies and reports discussed, particularly with regard to their results and recommendations for applying lessons in future planning.

Seeking to go further, this report has sought to also review research that asks and address reasons why it is often the case that lessons fail to be learned or applied in effective planning and response

Seeking to go further, this report has sought to also review research that asks and address reasons why it is often the case that lessons fail to be learned or applied in effective planning and response for psycho-social support after disasters. Thus the recommendations here seek to go beyond just suggesting the need for better and more planning, fundamental though this activity is. Rather the suggestion is that planners and responders needs and should seek to understand more deeply the nature of the communities they serve and the role and function of emergency planning and support within a broader political and administrative context as a pretext for effectively preparing to meet the needs of those affected by major emergencies.

Quarantelli highlights two key planning principles which reinforce the importance of adopting such an approach in order to be effective:-

'Community…disaster planning typically or usually assumes that people should adjust to the planning or the plans…realistic disaster planning requires that plans be adjusted to people and not that people be forced to adjust to plans' (Quarantelli 1981: 2-3)

'It is a mistake to equate disaster planning with the drawing up or the production of written plans ….Studies show that disaster preparedness planning is most effective when officials view the planning activities as an unending process' (Quarantelli 1981:2-4).

With this in mind, the following recommendations are proposed:

1) Current efforts to integrate processes of planning for humanitarian assistance as part of a truly integrated emergency management approach should be continued and actively promoted at local, regional, national and international levels. 'Integration' here includes promoting planning, training and exercising which address needs and activities relating to the medium and longer term phases of disaster rather than just focussing on the immediate and short term aftermath. It also reflects a key theme in this review which is the importance of addressing the relationship between disaster planning and response and everyday planning and provision for those in psycho-social need in our society and the importance of continuity where possible in identifying, acknowledging and addressing such need.

2) This review has discussed the importance of applying the principles of vulnerability analysis, risk assessment and risk management to psycho-social planning and response. In relation to the The National Capabilities Survey (2006) it is recommended that further work be be done to critically review the quality of assessment of psycho-social risk in local areas and the extent to which sufficient account is being taken by local and regional planners of the broader dimensions of vulnerability in pre-disaster psycho-social planning. The scope of local risk assessments (ie Community Risk Registers) may require broadening to achieve this.

3) An analysis and audit of psycho-social disaster plans should be undertaken in order to establish the actual levels of preparedness and organisational resilience for responding to major emergencies within and across areas of the UK. In developing auditing procedures and protocols reference should be made to the work already done by the Disasters Working Party (1991 but mostly still relevant today) which produced helpful checklists for tasks and actions in relation to psycho-social plans and services (1991: Part 2).

Examples of the sorts of issues to be addressed in such an audit include: whether or not local authorities have formulated specific social and psychological support plans as part of the emergency planning process; the appropriateness, relevance and currency of such plans; the degree and effectiveness with which social and psychological planning, procedures, training and exercises are

integrated into the framework and activities of corporate plans and of local and regional resilience forums; the extent to which Adult and Children's Services, Educational and Health Services have designated specific roles and responsibilities in plans and integrated these across other plans; and the frequency of training and updating of plans and protocols.

4) A key theme throughout this review has been the promotion of a 'person-centred' or 'user-based' approach. It is recommended that training and education in this field should specifically address behavioural elements of disaster and require planners to revisit assumptions about both 'victims' and helpers in order to understand the meaning and implications of such an approach. Plans and response efforts should focus on engaging victims as potential first responders by involving them in pre-incident education and awareness raising initiatives, as well as building on their capabilities, resilience and qualities of self-sufficiency in the face of disaster.

5) Education, training and planning should explore further the nature and meaning of psychological and social resilience within local communities. Emergency planning departments now have a duty to educate the public about local risks and emergency planning arrangements and warn and inform them during an emergency. However, beyond disseminating information, they could do more to actively engage the public in personal, family and community emergency preparedness activities. There are initiatives in the US and Australia which offer useful precedents for adaptation to a UK context.

6) Building on research into successful intervention included in this review, it is recommended that, whether directed toward the community, family, or individual, the emphasis for psycho-social interventions should be on empowerment and strategies aimed at enhancing social resources. As Norris et al highlight (2005) in practice this means they should draw upon and build strengths, capabilities, and self-sufficiency. At the same time a focus on self-efficacy does not mean that mental-health services are not needed but rather that such services should be delivered in a way that provides resources without threatening them (Norris et al 2006).

7) It is recommended that preparedness activities plan for proactive and widespread outreach to groups of people in the aftermath of incidents. This is in recognition of the fact that affected populations are likely to extend to areas beyond the immediate impact area of an event or "bull's eye" disaster model (Marshall 2006). Assessment and outreach strategies should include methods for addressing the needs of special populations such as children and include specialist support and advice as necessary. Such considerations should be included into psycho-social planning, training and response which should engage those professionals working with children and young people within the community, such as teachers, educational psychologists and youth workers, before as well as after incidents occur.

8) Communication and media strategies should be included as part of psycho-social planning and outreach strategies. This includes not only policies for working with the media in order to address issues of privacy and sensitivity in the treatment of those directly affected by incidents, but also in order to maximise opportunities for publicising and disseminating post-disaster support services as widely as possible.

9) Agreement should be sought on the most effective and appropriate ways of sharing data within and between agencies involved in disaster response, particularly in relation to information about those directly affected. Protocols should be drawn up which will maximise opportunities for sharing such data where beneficial and in line with the requirements of the Data Protection Act, while at the same time covering ethical issues such as confidentiality, privacy and consent. Disaster Action's Code of Practice on Privacy, Anonymity & Confidentiality (2006) provides a useful basis for further discussion and should be disseminated widely.

10) It is recommended that consideration be given to supporting the development of a central web-based resource relating specifically to psycho-social aspects of humanitarian assistance after emergencies. At present there is no single web-based repository in the UK for collating useful information in this particular field and, in particular, linking research, resources and literature within the fields of humanitarian assistance and emergency planning/management.. A range of websites can be searched to identify, for example, research references, details of specialist support services, leaflets and links to research and practitioner based resources, but having a focal point would be an advantage to future planners, researchers and providers of humanitarian assistance. In particular this would facilitate opportunities to set up support services more quickly and efficiently in relation to events including, for example, those occurring overseas but affecting UK citizens returning home.

The sorts of information/links that could be included on such a website include: guidance documents and research reports (spanning the fields of, for example, emergency planning and management; psychological/social care and welfare in emergencies; business continuity; disaster management; hazards research and the sociology of disasters), details of forthcoming events such as trainings, conferences and workshops, both in the UK and abroad; links to existing discussion forums discussing psycho-social aspects of emergency planning and trauma management; details of university course and research programmes specialising in relevant subjects; helpful leaflets and other resources for practitioners; and details of voluntary and other organisations specialising in humanitarian assistance, response and training.

11) Further research and development of evaluation tools for assessing humanitarian assistance programmes during and after service provision is recommended. Carefully designed and implemented evaluation activities can lead to improved services, can identify individuals and groups not being adequately served, and can possibly help garner additional resources for a community following closure of a service (NCCPHP 2006). They can measure project performance against expectations and allow for comparative analyses across events and responses. This review has highlighted the fact that many reports have acknowledged the importance of learning, recording and sharing lessons in order to refine plans and future responses. They purport to be evaluative; however many conclusions are based on anecdotal evidence and more often than not the subjective analyses of providers rather than users. Thus more needs to be done to develop more systematic, scientific and independent approaches to programme evaluations.

12) Building on point (11), it is recommended that opportunities are promoted for further interaction between researchers and practitioners specialising in the field of humanitarian assistance and disaster management. Experts have highlighted how the quality of both disaster research and practice will be improved immeasurably if the interaction between them is increased (Drabek 1986:416), yet the lack of a consistent funding source prohibits many potential opportunities. Examples of productive funded initiatives have included the Joseph Rowntree's funding of Tim Newburn's research, conference and workshop drawing together lessons learned and collated in the publication 'Journeys of Discovery' (Mead, 1996), yet such funded opportunities are few and far between. The Disasters Study Group (http://www.britsoc.co.uk) has also brought together researchers and practitioners for occasional meetings and conferences but such valuable networking opportunities are limited without a funding source and so collaborative opportunities for learning lessons and sharing best practice are being lost.

13) Efforts aimed at developing common professional standards for the training and accreditation of those on psycho-social response teams training should continue. The work being coordinated by the Department for Culture, Media and Sport through the Training Accreditation Standards Working Group should be extended to include the involvement of other national bodies with an interest and

15) Central government, through the Humanitarian Assistance Unit within the Department for Culture, Media and Sport, should continue to play a strategic role in promoting humanitarian assistance planning and response and in co-ordinating a cross-government approach to addressing the humanitarian needs and issues. In practice this means:-

Preparedness/planning - continuing actively to promote the importance of achieving humanitarian assistance planning and preparedness across government departments. This includes supporting activities highlighting the practical implications of the Civil Contingencies Act and the need for proactivity and accountability in addressing humanitarian issues at regional and local levels.

Immediate aftermath - coordinating strategic humanitarian assistance activities in the aftermath of incidents, including liaising with key partners fulfilling tactical and operational roles and ensuring that responders at regional and local level are meeting their legislative commitments and responsibilities to those in humanitarian need.

Aftercare - co-ordinating aftercare services for those affected in the medium and longer term aftermath of major emergencies. This is likely to include supporting efforts to secure financial support for those providing direct services related to humanitarian assistance which may be established at national, regional or local level after incidents. It may also include providing opportunities for those directly affected to address their collective concerns directly to government ministers and ensuring they receive a timely response.

In relation to aftercare there is an important difference to be noted between the political and strategic functions of the DCMS as a government department and those providing direct humanitarian responses and services. The distinction between the political role of the DCMS as a government department and the humanitarian role of those directly providing psycho social support services ('humanitarian' here referring to a politically independent function focussed on meeting fundamental human needs) should be clear and carefully maintained. Blurring these distinctions may draw civil servants into conflict with regard to their responsibilities, placing demands on them in relation to psycho-social support roles for which they are inadequately experienced and qualified. Basic training for civil servants joining the DCMS on the humanitarian aspects of emergences, the key principles of emergency management, and the role and function of psycho-social support services is recommended. At the same time, the Humanitarian Assistance Unit should be seen as a facilitator of services to individuals affected by a disaster, not as a provider of the services that such individuals may require.

Further Reading

Disasters Research Centre at the University of Delaware - http://www.udel.edu/DRC/

Hodgkinson P & Stewart M (1998) Coping with Catastrophe: A Handbook of Post-disaster Psycho-social Aftercare, Routledge London

Quick Response Reports: Post-disaster Studies Sponsored by the Natural Hazards Centre - http://www.colorado.edu/hazards/qr/

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Notes

Note 1 – Details of Major Incidents as presented by the Emergency Planning College (see http://www.epcollege.gov.uk/library_and_information_centre/index.shtm).

In presenting this database the College reports: 'The Major Incidents Database is compiled from the best information available, and where authorised information is available this data is used. However the database also includes many entries where official reports do not exist, and rather than exclude these incidents, details taken from newspaper and news bulletin reports issued at the time of the incident have been used. Please bear in mind that using these sources, the numbers of fatalities and those injured may vary from one source to another, and therefore not all reports on figures can therefore be guaranteed 100% accurate'.

Note 2 – Titles of information leaflets that were used on the website of the Tsunami Support Network

Coping with the effects of a traumatic event - your experience of the Tsunami
Coping with the Aftermath of Witnessing a Major Disaster
Coping with a Major Disaster
The Family and Crisis
Trauma and Teenagers
When Children Learn about Trauma
When Someone You Know has had a Traumatic Experience
When Someone Dies
What can Help
The Loss of a Child - What Helped Us
Services Provided by the British Red Cross
Disaster Support Groups

Appendix 1 – Model of Phased Provision, showing key psycho-social reactions, needs and provision at different levels of humanitarian response (drawing also on the work of Zunin & Myers (1992)).

Phase	Psycho-Social Reactions	Needs of People	Frontline/Operational Responders	Tactical Responders	Strategic Responders
Impact/immediate post impact: first few hours – Heroic phase	Shock, physical & emotional injury	Physical rescue & first aid; Shelter & safety; Information; psychological first aid	Response to alerts/call out; Delivery of physical & psychological support at designated centres/sites such as FRRCs, SRCs, rest centres etc	Manage callout & deployment; Ongoing co-ordination & liaison in relation to humanitarian service provision	Liaison & coordination with other strategic level responders; promotion & representation of humanitarian issues
Following hours/ first few days – Tunnel Vision phase	Searching & activity focused behaviour		Delivery of support services (e.g. through outreach & one stop shops): Helplines Reconciliation Family liaison Organised site visits Personalised support/advocacy Information eg leaflets, briefings, newsletters Compensation/disaster funds Funerals Return of property Memorials Inquests Reviews & inquiries Trials	Management of support services; Supervision & support of staff; Liaison with operational & strategic level responders; Implementation of proactive outreach & community strategies	Strategic coordination of humanitarian support services; cross-government & multiagency liaison; Ongoing liaison & support of tactical level responders in managing humanitarian response
Medium - longer term – Honeymoon phase	Normal post-traumatic reactions which usually diminish over time; Grief & mourning	Continuing safety, shelter, psychological first aid; reconciliation with family/friends; Information updates			
Longer longer Term – Disillusion through to adjustment, acceptance, recovery (note the ups & downs of this process)	Acknowledgment Adjustment Acceptance; Responses to trigger events & anniversary reactions	Ongoing access to support services & opportunities & choices to participate in support networks via family, social &/or disaster related community activities		Managing transition processes (e.g. from reception to assistance centres); Coordination between 'home' and 'away' services (e.g. site-based & outreach teams)	Ongoing leadership & participation in strategic decision making forums relating to issues such as funding, communications, & commemorative activities
	Post Traumatic Growth/PTSD	PTSD - referral to specialist treatment	Activating exit strategies; Facilitating contacts & bolstering natural support & disaster related networks, including support groups	Managing exit strategies & transition to ongoing support networks	Coordination of & participation in review & evaluation processes; strategic coordination of transition processes & decisions concerning longer term support strategies

Appendix 2 – Examples of Provision

	Examples of Provision/Provider	Sorts of Services Offered	Central or Local /One stop shop?	Support Groups	Information Dissemination	Who Delivered Services	Funding	Duration/ Flexibility
Aberfan 1966	Advice Centre (Council of Social Service); local psychiatric/GP services; family caseworker; local council of churches	Initial practical help & limited psychological support; community association facilitated by churches	Community-based advice centre but series provided through different depts + organisations	Community self help networks, Including some bereaved support groups	Through local community; word of mouth probably key	Various providers; no special disaster or trauma training; locally based providers	Family caseworker funded by local authority for 2 years;	Caseworker funding & services ceased after 2 years
Zeebrugge 1987	Initial info, reception centres & helpline run by Belgian Red Cross; m'agency coordinating group in Kent Eventually multi-agency Herald Assistance Centre set up (despite bureaucratic delays & some organisational rivalry Hodgkinson, 1999).	Providing info to relatives & survivors; accompanying families to hospitals & mortuary Helpline & proactive outreach/visits; First national outreach team after disaster	Herald Assistance Centre consisted of 2 teams – Home Team based SE Kent & Away Team beyond Kent; team included staff based in Midlands & London	Herald Families Association; action group campaigned for prosecution of ferry company etc	Mailshots to those known to be directly affected as bereaved/ survivors (though difficulties in collation of info/database); helpline; home visits	Away team: 4 FT social workers, 1 part time social worker, 1 psychologist & 3 OT nurses (team made up of 7 wholetime equivalents – a first in disaster response)	Service cost £320,000 in 15 months	Away team finished work 3 weeks after first anniversary; Home team closed 3 months later: decisions taken on funding vs. clinical grounds
Hillsborough 1989	Initial social services responses in Liverpool , Nottingham & Shuffled evolved into Inter-Agency Group reflecting regional response by authorities in Merseyside joined by other agencies in Merseyside & from other affected areas	24 hour helpline + staff helpline & staff counsellor; outreach contact with bereaved by social workers; individual & group counselling; newsletters; inquest support	Regional teams of social workers + coordinators. Central/high profile drop in-centre in Liverpool –received many referrals	Various talking groups set up, nature + degree of facilitation varied; Also bereaved families' support group (HFSG) + survivors' action groups	Media attention & newsletters; proactive outreach to bereaved, mostly within 48hous of the disaster; survivor contact prompted by survivors-sporadic & haphazard;	Varied- in some areas dedicated teams (based on other disasters); in other areas part of general casework; voluntary sector took over helpline	Funding and length of provision varied for different teams; funders incl local authority, private funding (Littlewoods) + Children's Society post	Length of provision varied from 4 weeks to 2 years; decisions based on various factors such as timing, funding, users etc
Oklahoma City 1995	Project Heartland was created by the Oklahoma Department of Mental Health and Substance Abuse Services. Services were provided free of charge	Outreach efforts included educational materials and information about services, debriefing sessions for workplace groups, and educational	Based at the Project Heartland Centre in Oklahoma	21 separate support groups established. Groups constituted on the basis of suggestions of individuals responding to	A quasi-public disaster relief planning workshop used to engage stakeholders (a first); media	From 5 original staff members, Project grew to 65 employees providing a comprehensive array of clinical,	FEMA supported Project - longest project thus far funded- $4,092,909.	FEMA funding was extended & three times ended on February 28, 1998. The Unmet Needs

	at the Project Heartland Centre, which housed a core group of clinicians	seminars on such topics as grief or traumatic stress.		outreach efforts. Group attendance and duration varied	strategy included educating media about responses to trauma	educational, and outreach services.	Funding was extended three times	Committee – filling in service gaps- contd to meet 5 years on
Dunblane 1996	27 family liaison teams (police and social workers) deployed to families; 24/7 drop in centre set up (forerunner to Dunblane Support Centre); psychologists worked with schools & support centre	practical & emotional support to bereaved families/families of injured; psychological briefings & info leaflets to schools; support at Inquiry & anniversary etc	Support Centre established in purpose built building in Dunblane. Aimed at anyone affected by the tragedy	Families supported the Snowdrop campaign (advocating for gun control); also Bereaved Parents' Group + Injured Parents' Group	Proactive outreach to families; publicity leaflet & regular briefing notes	Support Centre staffed by 'support workers' of various prof backgrounds- social work, psychologists, and youth & community workers.	Multidisciplinary strategic groups coordinated recovery activities; comprised of reps of Stirling Council, education, health, social services, police & health reps	Date of final closure unknown, but Support Centre still operational 2 years later; by that time main reason for visiting centre was for therapeutic work.
9/11 – US Response 2001	Multiagency family assistance centres set up at strategic sites, including at New York, New jersey & Washington + extensive federally funded projects	Range of practical & emotional services at FACs as well as longer terms community-based 'crisis counselling' using FEMA model	As well as family assistance centres, a vast range of other services were set up in new York State & New jersey through Project Liberty and Phoenix	Various support groups – facilitated and self help groups, set up. Many still active 5 years after the disaster	Various methods of publicity; media + websites; teleconferencing is used for some support groups	Range of human service & mental health specialists as well as community-based 'paraprofessionals' for FEMA projects	Federal funding supports many initiatives + other sources of private and non-profit sector funding was made available	Variation of programmes varied, but much of federal programmes now winding down.
Asian Tsunami 2004	Tsunami Support Network funded first by FCO & later DCMS; coordinated by British Red Cross (BRCS) with support of multiagency steering group; Family Liaison Officers deployed to bereaved families; DCMS later coordinated overall aftercare services	TSN - Helpline, website; facilitated local support groups; newsletters; national meetings. FLOs as point of contact for bereaved families	TSN operationally coordinated by BRCS with 'virtual' focal point of website; some liaison between centre + local services e.g. FLOs, social services, RC services etc; DCMS coordinated Cabinet Office multiagency meetings	TSN-facilitated talking groups – nature, membership & no. of meetings varied; independent group including bereaved/ survivors- Tsunami Support UK group-formed after a year	Some (limited) media coverage; proactive outreach via FLOs & other agencies e.g. GP Alert; website, newsletters; survivor contact initiated by them	TSN – staffed by BRCS staff/contractors; helpline supported by voluntary sector; FLOs provided by local forces; DCMS Humanitarian Assistance Unit coordinated aftercare services	Initial funding for Tsunami Support Network provided by FCO & later DCMS (cost: £120,000); start up funds provided for support group	Main activity of TSN completed within 14 months; transition included handover of organised activities to support group committee

Appendix 3 – Summary of Key Points & Best Practice Guidelines

Key Points

1) Disasters are about people and responding to disasters – pre, during and post impact – is about *managing and supporting people*.

2) Whatever definition is used, all major emergencies are not only physical events but also *psychosocial events* involving people.

3) The relationship between disaster planning and response and procedures and provision for *meeting everyday need* in society should be understood and addressed by anyone involved in providing humanitarian assistance.

4) Current initiatives examining the *implications of terrorism* and the role of services provided internationally (such as through the Foreign & Commonwealth Office) should be considered alongside the recommendations of this review.

5) Analysis of the *ripple effects of incidents* reminds us to consider the broad implications of events while also addressing *differential levels of risk* in relation to particular individuals and communities.

6) Emergency managers should be made aware of *common myths* about human behaviour in disasters and address their plans accordingly.

7) The more *information is available* about what to do in an emergency the more likely it is that people will feel empowered to act in an informed, responsive and responsible manner.

8) Wrongful *assumptions about victims and helpers* and their capabilities, resilience and qualities of self-sufficiency should be addressed in emergency planning, training and education.

9) Planners should *expect and plan for convergence* after disasters, including promoting the potential benefits of training and engaging volunteers.

10) Concepts of stages or phases of reactions after disaster are helpful, though we should beware of an *over-simplistic time-lined approach.*

11) Discussion about the *inappropriateness of stereotyping* (for example about *the* bereaved and *the* survivors, or about ‘good’ or ‘difficult’ victims) should be included in education and training programmes.

12) Disasters may include particular types of loss, such as *multiple and ambiguous loss*. This highlights the significance of searching activities and the importance of providing timely, detailed and accurate information after disasters.

13) Most *traumatic stress reactions after disaster* are temporary. Information and activities which normalise reactions, protect social resources and signpost further sources of support are fundamental to good psycho-social response.

14) In the case of extreme traumatic reactions, such as *Post Traumatic Stress Disorder*, referral to specialist help and treatment is necessary.

15) The emphasis on interventions should be on *empowerment* i.e. drawing upon resilience and building strengths, capabilities and self-sufficiency.

16) A *thorough understanding of the phases of disaster*, as well as focused attention to the phase that individuals are experiencing, is essential to successful outreach.

17) Reports and guidelines on principles and standards of care grounded in *rights-based approaches* should be included in emergency planning, training and education.

18) *Proactive outreach support*, including personalised support for bereaved families and contact between those affected, has been found to be most helpful from the earliest stages.

19) Providing psycho-social support includes facilitating opportunities for those *seeking out others* to have the opportunity to be in contact and meet informally as soon as possible after the event.

20) Strategies for *continuing to outreach and provide information* are essential if psycho-social support is to be effective.

21) Visits to *disaster sites* should be expected and carefully coordinated.

22) The identification, custody and return of *human remains* are very important forms of family assistance and opportunities for viewing bodies and remains is an essential part of psycho-social support.

23) Attitudes and protocols relating to the return of *personal property* to the bereaved and survives should reflect a rights-based approach.

24) While there continues to be interest in setting up and contributing to appeal funds after disasters, existing guidelines and practices have failed to prevent recent *disaster funds* from becoming 'second disasters'. More research and guidance is needed in this area.

25) Different kinds of *support groups* may function to provide practical and emotional support for those directly affected by disasters. Coordinators of psycho-social support should be clear about the role and function of these groups and respect their independence where appropriate

26) *Religion, rituals and remembrance* may play a fundamental role for those affected by disaster. It is important to acknowledge and address the meaning

and significance of decisions surrounding commemoration and the relationship between these and recovery for those directly affected.

27) The *development of service provisio*n over the last twenty years or so has reflected better understanding of the nature of the psycho-social effects of disasters and the need to plan for a coordinated approach to emergency planning and response.

28) The evolution towards this *centralised and coordinated approach* to support has included the development of *one stop shop approaches*. In practice there are various ways in which this concept has been applied.

29) Some common themes and key lessons have emerged from experiences of setting up *longer term assistance programmes*. These highlight the benefits of one stop shop and other approaches and how potential flaws may be overcome

Best Practice Guidelines

1) As well as short term impacts, joint planning, preparedness and training should focus specifically on addressing medium and longer term elements of disaster recovery within and across disaster-impacted communities.

2) Planning and response will benefit from including consideration of one stop shop approaches. The scale of needs arising from a catastrophic event is likely to involve multiple sites and may necessitate multiple assistance centres and support teams.

3) A flexible and appropriate (as opposed to an over-prescriptive and imposed) approach is important and proactive outreach and communication strategies should be included.

4) Providers should be prepared to address the challenge of planning for psychosocial support without any clear indication at the outset of the scale of the impact or demands of the aftermath.

5) Models should reflect principles of community resilience and support processes of self-healing. They should draw on the potential for individuals and communities to participate in determining their own strategies for recovery and development. At the same time a focus on self-efficacy does not mean that mental-health services are not needed but rather that such services should be delivered in a way that provides resources without threatening them.

6) Providers should ensure programmes are fully accessible (e.g. physically, culturally and economically) by target populations, including special populations.

7) There can be advantages to obtaining community input and participation in the development of service goals and design of recovery strategies and programme content.

8) Only carefully screened and qualified providers should be enlisted and both specialist and multidisciplinary teams may be necessary to deliver high-quality, culturally sensitive services. Where appropriately trained and available, local grass roots community based agencies will significantly increase reach into the community.

9) Providers should be prepared to work within a potentially conflictual environment where political decision making processes, ownership and 'turf' issues abound.

10) Strategic decision-makers should be prepared to be creative and flexible in researching, designing, and implementing services. At the same time they should be critically reflective in addressing the unique challenges of each disaster. Most provision after disaster has, by necessity, needed to include some element of innovative thinking and action.

11) It is likely that the maximum impact of outreach efforts will be in the initial stages, e.g. the first 12 months. Services may be needed for longer but are likely to be reduced in size and focus over time. Caution should be exercised in basing decisions on time-scales alone or equating need, legitimacy, value or the effectiveness of provision simply with the number of users. Attention to exit strategies from the outset and regular programme review is crucial.

12) Service reviews should include user evaluation, dissemination of lessons learned and suggestions for future planners/providers.

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