Review of the literature on best practices before, during and after Collective Trauma Events

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CONTENTS

INTRODUCTION

This literature review has been prepared as part of the project **Best Practice Guidelines: Supporting Communities Before, During and After Collective Trauma Events (CTEs)**.

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This literature review lays the foundation for the project's survey by identifying current best practices *Before, During and After Collective Trauma Events*. The best practices identified in the literature will be turned into statements which will be tested through a survey with a large sample of experts internationally. The findings will then inform the development of practical guidelines to support effective and timely responses to CTEs through preparedness and post-incident agendas.

The purpose of this literature review is to:

- present key themes from the existing literature which provide the background for the current study
- identify areas of good practices related to the preparation for, response to and recovery from CTEs
- identify topic areas and themes for further exploration in a survey

The first part of the review briefly outlines the nature and examples of types of Collective Trauma Event (CTE). Observations about the resilience and responsiveness of the public are then explored in further detail. Here the importance of promoting social support and responding to multilevel impacts is underlined. Research studies focussing on community resilience, social capital and the identification of evidence-informed principles to guide interventions are introduced along with their practical implications. Gaps in areas of knowledge are referred to in order to suggest exploratory themes for the project's primary research.
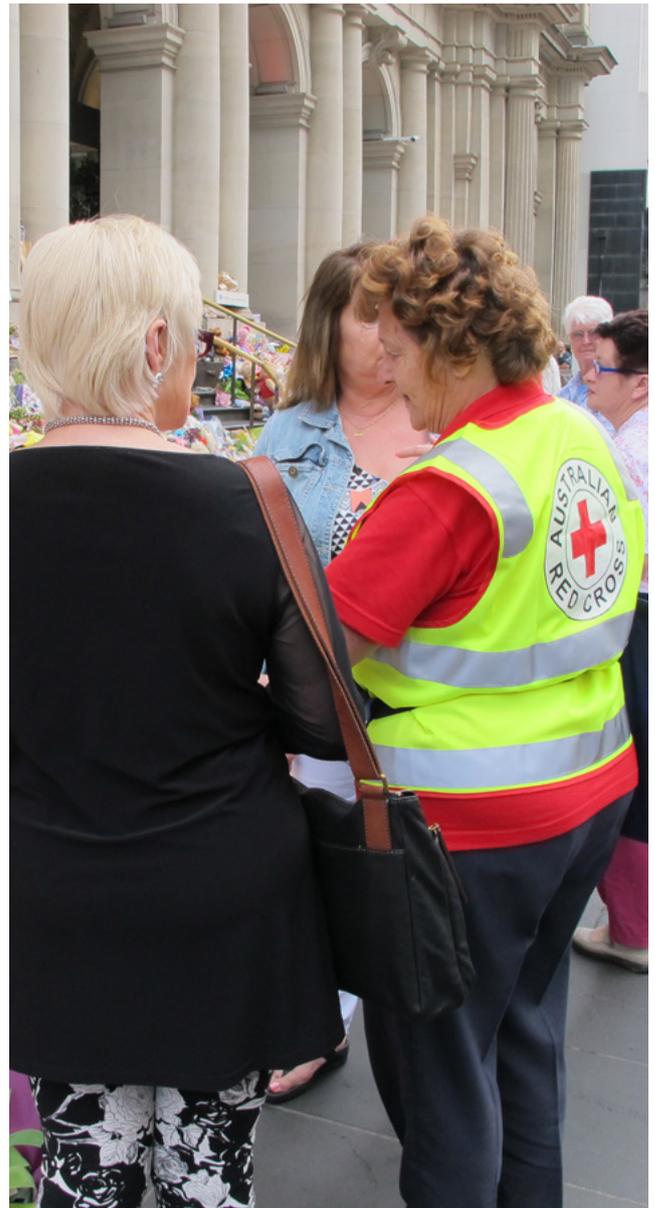
The role of formally organised support services is discussed in section five which draws together guidance for addressing medium and longer term needs arising from Collective Trauma Events. Poor practice in the form of discontinuity in service planning and provision or barriers to accessing care may be mitigated by ensuring that effective referral mechanisms are in place.

The final section addresses the need for affected individuals and wider society to make sense of Collective Trauma Events (CTEs). Formally and publicly acknowledging, recognising and respecting the impact of CTEs and their effects on victims is part of wider meaning making.

WHAT IS A COLLECTIVE TRAUMA EVENT?

Definition

For the purposes of this study a Collective Trauma Event (CTE) is defined as an event, irrespective of the hazard which results in a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of community.

Commonly occurring elements of these events include:

- Witnessed violence
- Horror
- Public grief
- Strong sense of injustice
- Intense media coverage
- Highly political
- Judicial or public enquiry process
- Identification with victims or the locations

Not all disasters are Collective Trauma Events (CTEs). To meet the definition above these events must have an impact on the broader community and challenge people's typical understanding of the way the 'world works'.

Examples of the kinds of collective trauma event addressed in this review include natural and humanly-caused disasters including acts of terrorism and other extreme acts of violence. The characteristics of circumstances and context determine not only the occurrence of any particular collective trauma event, but also the nature of its impact, including the intensity and severity of its consequences for those affected.

Adverse psychological effects may include immediate and longer terms reactions such as those associated with shock, traumatic stress, sudden, traumatic loss and complex grief and mourning (Ursano et al 2007). It is important to understand that any individual's perceptions around any particular CTE and the emotions and behaviour associated with them are likely to be strongly influenced by the prevailing social and cultural environment (Harms 2015). Furthermore, reactions and responses will be filtered through their pre-disposing personal characteristics and experiences as well as influencing factors such as the nature and quality of individuals' relationships, social networks and support following exposure(John Hopkins and Red Cross, 2008). For these reasons it is to be expected that levels of need, vulnerability and resilience will vary across all those individuals affected by any single CTE.

This means that seeking to understand and address the psychosocial impacts of any specific incident - collectively and/or for those individuals affected - requires more sophisticated assessments than just measuring levels of physical destruction or using statistics such as the number of people killed or injured as benchmarks. By way of example, seemingly negligible incidents in which no one is killed or injured may raise communal levels of fear and anxiety and also impact on collective social behaviour in an environment where a heightened public awareness and sensitivity already exists. Additionally, individuals with a predisposition to anxiety may be particularly susceptible to the psychological impacts of such events, even if they are not directly involved.[1]

In today's technological world where the prolific use of social media means details and images of events are widely disseminated from the moment disasters begin to unfold, a large mass of people can be affected by incidents that may not even happen in their immediate vicinity (Silver and Garfin 2016). Moreover, the seemingly random chance of becoming a victim of circumstances involving ordinary people going about their daily lives may increase the sense of vulnerability and personal risk, even altering the outlook, lifestyle and behaviour for some people. (Antonius, 2016)

All of this raises important questions about how those affected may remain resilient in the face of adversity, about the nature of their psychological and social needs and about where sources of support can and should come from. These kinds of questions provide the context both for this project and for this literature review.

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1. By way of example, on November 17 2017, some shoppers reacted with panic and confusion after a fire alarm was activated at a London shopping centre. This was during a period when the UK experienced 5 terrorist attacks, 4 of them in London. As well as heightened general public awareness, evidence highlighted the particular vulnerability and impact among certain social groups. The number of children and young people seeking help from mental health services in Manchester and London, for example, spiked in the wake of terrorist attacks there according to the Royal College of Psychiatrists (RCP) (Marsh, 2017)

PSYCHOSOCIAL REACTIONS AND EARLY RESPONSES TO CTE

Diverse and broad-ranging impacts

Given the diverse nature and exposure to differing kinds of collective trauma events, it is unsurprising that over time their psychological, social and political impacts too can be diverse and their ripple effects wide-ranging. As well as those within the immediate vicinity, those affected also includes people more marginally or indirectly involved (Silver and Garfin 2016). The ripple effects may embrace, for example, direct victims' relatives, eyewitnesses, first responders, and broader communities. This extends to cross-border and virtual communities given the increasing accessibility and exposure to events through technologies and social media.(Holman, Silver and Garfin 2014)

Initial triage and impact assessments usually differentiate between deceased persons, those who are physically injured and physically unharmed survivors. Historically the tendency has been to assess, quantify and address the impact of major emergencies primarily in terms of the numbers of deceased and the needs of physically injured victims and it followed that the response to a situation of mass emergency was largely considered from a purely medical-therapeutic point of view (Seynaeve 2001:3). Today by contrast our understanding of incidents and their impact reflects a much wider understanding of behavioural and other psychosocial impacts over time.

It is not uncommon to refer to and discuss the ripple effects of individual events and a number of studies and reports focus their analysis on the nature and relative impacts of events across a spectrum of affected groups. Back in 1999 A J Taylor built on earlier work identifying the stressful effects of disasters and introduced schema for classifying disaster victims (Taylor, 1999). Today such schema may include descriptions of ripples or circles of victimisation and discuss the toll of events on micro, meso and macros levels. A recent report for the European Parliament, for example, outlines the reach of terrorist attacks from those directly involved through to broader social circles and entire communities, crossing borders and cultures, and finally leaving a mark on the societies we live in (Ivankovic et al 2017:24).

The impacts of events are not all negative

At the same time it is important to note that the impacts of such events and reactions to disasters, both during and after they strike, are not all negative. Experience frequently highlights how witnesses, bystanders and survivors in situations of mass emergency react spontaneously by offering help, comfort and compassion to victims, even before emergency services arrive on the scene (Nagakawa and Shaw 2004, Graham, 2017, Perry and Lindell, 2003). Experience has also frequently shown that the suffering and misery of others can arouse strong feelings of human solidarity, empathy and a desire to give mutual assistance during these impact phases with individuals rallying to help and support friends, neighbours and strangers (see, for example, Cocking and Drury, 2005).

There is also evidence to suggest that in the days after collective trauma events there may be a rallying of social cohesion and increased social solidarity, albeit usually short term rather than a permanent state of affairs. This has been referred to as the 'honeymoon' phase (Samhsa, 2018) and can also relate to circumstances where a collective sense of pride, resolve and togetherness is enhanced (Ryan and Hawdon, 2008).

Resilience and responsiveness of the public

Internationally, an increasing appreciation of the resilience and responsiveness of the public during crises has resulted in the development of tools to enable them to act effectively during emergencies, including where first responders are not on scene. Examples include the Citizen Aid app (http://citizenaid.org/), developed by UK civilian and military clinicians to equip members of the public with the basic knowledge and skills to respond to serious injury from bomb blast, gunshot and stabbing in the event of a major emergency. Such initiatives reflect a wider ideological shift away from seeing the public as passive victims reliant solely on external help in favour of approaches which tap into individuals'

CASE STUDY

Emergency Responders and CTE

A growing appreciation and public acknowledgement of the impact of CTE on emergency responders has been highlighted following a series of terrorist incidents in London and Manchester. Countering traditional stigma and a reticence to speak openly about psychological stress and trauma, a number of responders - from operational through to more senior responders - gave media interviews following these events and acknowledged the personal impact of dealing with those disasters (see, for example, Evans, 2017).

The impact on the most senior of commanders has also been publicly discussed. Following a fatal fire at a multistorey tower block which killed over 70 people, London Fire Brigade Commissioner Dany Cotton gave several interviews highlighting the psychological impacts on responders, including herself, and the important role of psychological support services and counselling. She stated: 'It was traumatising because of the scale of it. None of us had faced that before. You'd have to be a robot not to be affected' (Warrell, 2017)

In 2015 MIND, a UK Mental Health charity launched a pilot Blue Light Programme focussing on improving the mental health of emergency services ('blue light') staff and volunteers in England. In 2017 the programme received a further £1.5m of government funding following the Grenfell Tower fire and terrorist incidents in Manchester and London. Its work includes tackling stigma around mental health, supporting workplace champions and providing online resources on PTSD, trauma and coping with traumatic events. Such examples suggest awareness and willingness is growing to actively discuss and address psychological needs and support for emergency responders following today's CTEs (https://mind.org.uk/news campaigns/campaigns/bluelight/our-blue-light/).

and communities' capabilities as an asset during emergency response and recovery (Perry and Lindell, 2003).

It also highlights the importance of addressing early information needs and organising the distribution of information for both members of the public and those directly affected by events from the moment they strike (Ivankovic et al, 2017), a theme discussed further in section six.

Early psychosocial interventions following CTE

As our understanding of psychological trauma has increased more attention has been paid to ways of addressing the specific psychological impacts of collective traumatic events. This includes addressing the effects on uninjured survivors, bystanders, relatives and first responders as well as wider social groups such as media personnel (e.g. DART, 2014) and providers of longer term psychosocial and forensic services (e.g. Samhsa, 2018a; Glaysher et al

2016). Although research shows that most people affected by of disasters, terrorism or other traumatic events recover on their own merit, a significant minority of them develop long-term disaster-related problems (Norris, Friedman and Watson, 2002).

In view of these consequences the importance of timely and appropriate psychosocial help for disaster victims has been identified and this has led to the development of several initiatives outlining guidance and standards for delivering psychosocial care after collective trauma events (Te Brake and Duckers, 2013). These include guidelines such as those produced by the Inter-agency standing committee (2007), Australian Centre for Post-traumatic Mental Health (ACPMH, 2007), NATO (NATO Joint Medical Committee, 2008 and the UK's National Institute for Clinical Excellence (NICE, 2005). In this context 'psychosocial' strategies refer to the provision of early interventions such as Psychological First Aid (PFA), screening and activities aimed at the prevention of longer term mental health impacts such as Post Traumatic Stress Disorder (PTSD).

Early psychosocial interventions aim to promote natural recovery and the use of natural resources, identify people who need acute psychological help, and to refer and if necessary treat those who need acute psychosocial help (Hobfall et al 2007).

An interesting study with European experts has found that despite there being a very high level of agreement on evidence-based psychosocial care principles, there is a lag in terms of the extent to which recommendations are actually brought into practice (Te Brake and Duckers, 2013). In their study Te Brake and Duckers explain this in terms of motivation, capability and opportunity, the latter being dependent on external factors such as time, resources and organisational support – 'not all countries are able to provide adequate support and resources to create appropriate opportunity to actually implement norms into practice'. An important question of relevance for this present study then is the extent to which guidance translates into perception, knowledge, planning and practice.

Wider research into risk and resilience highlights that psychological outcomes of collective trauma events are multiply determined and that there are social and psychological factors beyond mere exposure to an event that predict outcomes, all of which could potentially be used to inform the design of effective intervention programs (Watson et al, 2011:483). The next section focuses on the impact and role of factors such as social and community aspects and their relevance for broader social and community-focussed strategies and interventions.

SUMMARY

- The impacts of a CTE may reach well beyond those 'directly' affected

- Good practice guidelines have been established in Australian and internationally for the delivery of early psychosocial care, including PFA, following collective traumatic events

- Despite a high level of agreement of evidence based psychosocial care, there is a lag for these recommendations to be implemented into practice

- There are social and psychological factors beyond exposure to CTEs which play a role in outcomes for those affected

- The effective implementation of psychosocial strategies requires resources and services being in place

COMMUNITY DIMENSIONS AND PRACTICAL IMPLICATIONS FOR PSYCHOSOCIAL STRATEGIES

Disaster planning, training and response activities have commonly prioritised individual mental health and individually-based, longer term interventions within psychosocial strategies. While focusing on individual impacts and clinical treatments for disorders such as PTSD, some specialists within the disciplines of psychology and psychiatry warn against over-emphasis on personal vulnerability and psychopathology (van Ommeran et al, 2005, Bonnano 2009). They highlight the importance of planning around resilience with regard to early mental health intervention following emergencies:

'Just as we find it difficult to accept that the idea of a panic prone public is just a myth, we also find it difficult to accept that, in general, people are rather more resilient than people like us – experts – think they are. Be it psychiatrists, politicians or planners,

there is a long history of overestimating vulnerability and underestimating resilience stretching back many generations' (Greenberg and Wessley, 2017).

Across the literature there are also calls for a stronger emphasis on community dimensions, community resilience and approaches which integrate mental and broader public health responses following CTE. By way of example in their international handbook sharing knowledge and care based on the trauma of terrorism (2005) Danieli et al argue that while a public mental health perspective has occupied a more meaningful place in the literature on natural disaster, a more community-oriented approach is needed in relation to human-made disaster which focuses on wellness, and is collaborative, multiagency and multidisciplinary (2005:781).

Promoting social support

It has long been acknowledged that psychologically-based interventions alone, however well organised, will not bring total relief of suffering (van Ommeran 2005). Back in 2001, for example a European policy paper emphasised that the most important psychosocial support for those involved in mass emergencies results from the helping, healing and emancipating social mechanisms involved in interpersonal relationships and social networks (Seynaeve 2001:2). This kind of observation highlights the important role collective activities can make and the function of social networks and community dynamics within psychosocial strategies following mass trauma events.

Hence good practice guidelines on mental health and psychosocial support in emergency settings reflect an emerging consensus on good practice among researchers and practitioners, a core principle being that 'in the early phase of an emergency, *social supports* are essential to protect and support mental health and psychosocial well-being' (IASC 2008:5).

Responding to multilevel impacts

By their very nature collective traumatic events affect large numbers of people and can have extensive effects across societies, from the level of the individual and family, through to community and national impacts (see Figure 1).

Researchers have variously focussed on individual, family, neighbourhood, community, societal and even global impacts and the role of protective factors and interventions across these levels of social support are all considered (Shamai (2015), Hawdon and Ryan (2011); Hobfoll et al 2007; Chrisman and Dougherty (2014)). Such studies demonstrate the importance of enhancing family and community-based social support, social relationships and social networks within psychosocial strategies. Indeed, current evidence-informed frameworks recognise that post-disaster interventions must occur at multiple levels (individual, family and community) in order to be effective in building community resilience (Norris and Stevens, 2007).

The focus on social consequences and collective response to disaster is not new. Since its foundation Disaster Sociology has highlighted the social dimensions of disasters, their impacts on family and community interactions and relationships and the role of social support processes in post-disaster functioning (e.g. Barton, 1969; Erikson, 1976; Quarantelli and Dynes, 1977).
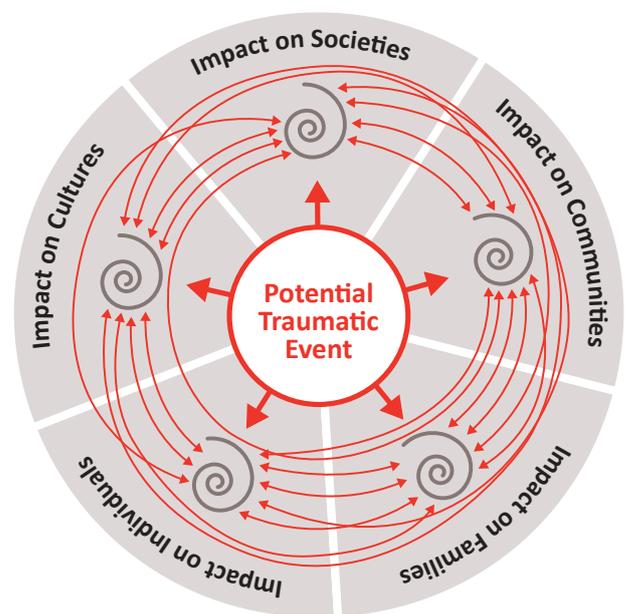
Figure 1 Systemic impact of collective and national trauma (Shamai 2015:94)

Community resilience, networks and relationships

The notion of community resilience has been much discussed in relation to collective trauma events, not least in relation to its role in disaster readiness, post-disaster interventions and overall community wellness (Norris and Stevens, 2007, Gibbs et al 2016, Aldrich 2017). Despite the proliferation of interest and research papers focussing on this topic, however, 'community resilience' remains an amorphous concept which has been variously understood and differently applied across studies and research groups. Patel et al (2017) highlight this in a systematic review of the definition and

application of 'community resilience'. They conclude that 'In essence, depending on one's stance, community resilience can either be seen as an ongoing process of adaptation, the simple absence of negative effects, the presence of a range of positive attributes, or a mixture of all three' (Patel et al 2017). This inconsistency is unhelpful generally and clarification is needed when it comes to specifying the practical role and relationship of community resilience to psychosocial strategies following CTE.

While commenting on the unhelpful lack of agreement over the meaning and measurement of 'community resilience', Patel et al advise focussing instead on those common elements of community resilience found within the literature based on the various definitions they identify. Their helpful paper highlights nine particular elements of resilience[2] that have been consistently outlined as constituting community resilience as it applies to disasters and for our purposes these offer a useful focus for *considering how communities prepare, respond to and recover from collective trauma events*.

One of the most commonly identified important elements of community resilience is community networks and relationships. The literature suggests that positive effects on a community and its members can occur during a crisis when its members are well connected and form a cohesive whole: 'the connectedness of a community, sometimes called its 'social network', tends to be defined by the linkages within a community' (Patel et al, 2017).

Creating links among community members based on social relationships and/or between communities are examples of 'connectedness'. The cohesion of a community is based on the nature of these links, typically described as weak or strong ties (Putnam, 2000) . Several factors which determine the strength of a tie, including trust and shared values might be relevant to enhanced community resilience. Furthermore, according to the literature, the connectedness of the networks and their cohesion are important aspects of social capital which conceptually focuses on bonding, bridging, and linking (Patel et al, 2017).

2. The nine core elements are: local knowledge, community networks and relationships, communication, health, governance and leadership, resources, economic investment, preparedness, and mental outlook (Patel et al, 2017).

CASE STUDY

Building social capital after Hurricane Katrina

Hawkins and Maurer (2010) describe how individuals affected by Hurricane Katrina were able to draw on positive social capital as a survival mechanism, as a strength builder and as a resource for survival and rebuilding in the aftermath of the disaster. In addition to the *bonding social capital* in the form of helping those close to them, a system of *bridging and linking social capital* exchanges took place in which people provided and shared information, resources, supplies and food. In these instances bonding, bridging and linking social capital were instrumental in aiding participants to prepare for, endure and mutually aid one another before and during the storm, in addition to recovery following the floods.

This reinforces the findings and approach of Aldrich (2012) whose work also highlights the critical role of social capital in the ability of communities to withstand disaster and rebuild both the infrastructure and the ties that are at the foundation of any community. From an examination the aftermath of both Hurricane Katrina and other post-disaster responses he concluded that those with robust social networks were better able to coordinate recovery. In addition to quickly disseminating information and financial and physical assistance, communities with an abundance of social capital were able to minimize the migration of people and valuable resources out of the area.

These studies show that when it comes to CTE social ties can provide emotional support, information and collective action, lessening the effects of trauma, allowing people to grieve, and helping them work through their adversity by creating and offering support (Aldrich, 2017). Psychosocial strategies should therefore include capitalising on the healing power of building connections between people and communities.

'Social capital' refers to direct and indirect resources that are a by-product of social networks and social support systems amongst family, friends or community members (Putnam, 2002, Hawkins and Maurer 2010:1778, Aldrich 2012). Norris and Stevens (2007) include a variety of important capacities under the umbrella of social capital, including effective organisational linkages, social support and social influence, sense of community, place attachment, and citizen participation (2007:321). Community resilience, they suggest, emerges from these and other interrelated capacities interacting in a positive process of adaptation following adversity.

Building social capital and promoting community resilience

Social Capital literature differentiates three types of social capital: bonding, bridging and linking (Putnam, 2000, Hawkins and Maurer 2010, Aldrich 2012):

- Bonding social capital refers to relationships amongst members of a network who are similar in some form

- Bridging social capital refers to relationships amongst people who are dissimilar in a demonstrable fashion, such as age, socio-economic status, race/ethnicity and education

- Linking social capital is the extent to which individuals build relationships with institutions and individuals who have relative power over them (e.g. to provide access to services, jobs or resources).

The facilitation of peer support groups is a practical example of a psychosocial strategy that promotes connectedness and bonding or bridging social capital. Eyre (2006) distinguishes between different types of post-disaster support group ('action groups' and 'facilitated talking groups') and highlights the function of post-disaster groups as part of psychosocial support networks for bereaved people and survivors following various types of disaster (Eyre, 2017; Eyre and Dix, 2014). Wills (2017) and Watkins (2017) also highlight the role of bereaved and survivor support groups after disasters such as the 2010 Canterbury earthquake and terrorist attacks and the practical implications for their organisation and facilitation.

A number of studies have further explored the relationship between social capital and disasters; this includes the examinations by Hawkins and Maurer (2010) and Aldrich (2012) of social capital after Hurricane Katrina (see Case Study above). In terms of other types of CTE, Arvanitidis et al (2016) examined the extent to which major terrorist events in four European countries affected two key aspects of social capital, namely institutional and social trust. The data used was drawn from European Social Surveys for the years 2004, 2012 and 2014. Results reported indicate that terrorist incidents can trigger social dynamics that affect trust attitudes; however, these effects are short-lived and dissipate rapidly.

McCoy et al (2017) also examined the impact of terrorism on social capital and like Arvanitidis et al their study focussed in France following the 2015 Charlie Hebdo attack in Paris. Their striking results demonstrated that terrorism had a significant positive causal effect on social capital: 'The effect seems to be driven by an increase in institutional trust, interpersonal trust, as well as engagement in social networks. Our results are in consonance with the hypothesis of a "rally effect."'(2017:12-13). Like Aranitidis et al they also found that the impact of terrorism on social capital is at its peak right after the terror attack, but quickly reverts to pre-attack levels.

In their conclusion McCoy et al draw attention to the opportunities wrought by the increase in social capital in the immediate aftermath following a terrorist attack. These include diffusing threats of future terrorist attacks since it is found that social capital is positively associated with increased [emergency] preparedness and with increased concern about future terrorism events. They also suggest that the increase in social capital following an attack can, perhaps, be used to mitigate post-terrorism popular uprisings and/or inter-ethnic group conflicts (2017:13).

In addition to these opportunities, the value of the concept of social capital lies in its highlighting the value of enabling, supporting and enhancing psychosocial approaches which focus on the person-in-environment, address the level of the collective as well as the individual, and actively promote positive, functioning relationships between individuals, social groups and communities. Furthermore, interventions

that promote community resilience appear to hold considerable promise for promoting essential evidence-based principles in the aftermath of disaster, namely safety, calmness, hope, efficacy and connectedness (Norris and Stevens, 2007:327).

Essential elements of intervention following CTE

In what is now considered a seminal paper (Norris and Stevens, 2007), Hobfoll et al (2007) developed a set of five evidence-informed principles to guide psychosocial interventions in the aftermath of disasters and mass trauma. These principles have since been recognised internationally as a valuable framework for disaster response and research initiatives and the article delineating them has been acknowledged as one of the most influential psychiatry articles of the previous four years (Watson et al 2011:484).

The five principles are:

a) promoting a sense of safety,

b) promoting calming,

c) promoting a sense of self-efficacy and community efficacy,

d) promoting connectedness, and

e) instilling hope

Hobfoll et al note that these five elements are not reserved only for traditional psychological interventions (e.g. counselling and therapy) but are promoted within well-functioning social systems and structures. The presence of the five elements has been correlated with positive outcomes including increased abilities to successfully decrease stress levels and function adaptively following exposure to extreme stress (Hobfoll et al, 2007).

Table 1 Expert Consensus Efforts on Disaster Behavioural Health Intervention (Watson et al, 2011:485).

- Be proactive/prepared ahead of time, pragmatic, flexible, and plan on providing the appropriate services matched for phase across the recovery period.
- Promote a sense of safety, connectedness, calming, hope, and efficacy at every level.
- Do no harm, by:
  - Participating in coordination of groups to learn from others and to minimize duplication and gaps in response;
  - Designing interventions on the basis of need and available local resources;
  - Committing to evaluation, openness to scrutiny, and external review;
  - Considering human rights and cultural sensitivity;
  - Staying updated on the evidence base regarding effective practices.
- Maximise participation of local affected population, and identify and build on available resources and local capacities (family, community, school, and friends).
- Integrate activities and programming into existing larger systems to reduce stand-alone services, reach more people, be more sustainable, and reduce stigma.

- Use a stepped care approach: Early response includes practical help and pragmatic support, and specialized services are reserved for those who require more care.
- Provide multilayered supports (i.e., work with media or Internet to prepare the community at large; facilitate appropriate communal, cultural, memorial, spiritual, and religious healing practices).
- Provide a spectrum of services, including:
  - Provision of basic needs;
  - Assessment at the individual level (triage, screening for high risk, monitoring, formal assessment) and the community level (needs assessment and ongoing monitoring, program evaluation); Psychological First Aid/resilience-enhancing support;
  - Outreach and information;
  - Technical assistance, consultation, and training to local providers;
  - Treatment for individuals with continuing distress or decrements in functioning (preferably evidence-based treatments like trauma-focused cognitive–behavioural therapy.

Practical implications for psychosocial strategies

Since their publication in 2007 Hobfoll et al's approach has been endorsed internationally as a framework for disaster behavioural response and these essential components have been included in a variety of consensus documents based on the findings and recommendations of a number of expert panels. Watson et al have summarised the commonalities across these guidelines and recommendations in table form (see above) and suggest these chart a comprehensive course for both individual and public health efforts going forward.

Further work has focussed on seeking to help guide and direct prevention and intervention practices based on these principles and recommendations, and on making connections with the evidence around social capital and community resilience. Norris et al

(2008), for example, notes that community resilience can be assessed in terms of community resources that are robust, redundant, or rapidly accessible in four primary areas: (a) economic development (economic growth, stability of livelihoods, and equitable distribution of income and assets within populations); (b) social capital (the way individuals invest, access, and use resources embedded in social networks), including social support, sense of community, sense of place, attachment, and citizen participation and leadership; (c) information and communication; and (d) community competence (collective action, collective self-efficacy, effective and trusted information sources, plans, and decision making).

Practical examples of using these intervention principles can be found in the literature. Separation from family members is acknowledged as one of the most stressful aspects of disasters.

Research from the Black Saturday Bushfires (Richardson et al, 2017) suggests that it can also lead to long term mental health issues. In the event of a collective trauma event, families may be separated as a result of loss of communications or transport systems. It is therefore imperative to provide the ability for family members to check in with each other and be reassured they are safe. The Australian Red Cross deliver the Register.Find.Reunite system on behalf of Police and other agencies in the immediate aftermath of disasters, taking enquiries from friends and families about people in the affected area, taking registrations and enquiries from people over the phone through an Inquiry Centre, reconnecting loved ones through the matching function of the system, or assisting police to identify missing persons through tracking numerous enquiries for specific individuals.

Mindful that a gap remains in bridging the research and practice, Gunderson et al (2012) seek to identify further strategies that can be used by those charged with disaster planning and response to inform their practices. They describe their work in Colorado which focuses on actively incorporating the evidence-based principles and Disaster Behavioural Health Interventions identified above through strategies of disseminating, service delivery and prioritisation/validation.

Dissemination includes promoting "buy-in" from existing emergency response partners, achieved by securing stakeholders' understanding of the importance of considering psychosocial aspects of emergencies in immediate and mid-term intervention planning and implementation. Service delivery involves the integration of the five essential elements into the programmes, practices, and policies of all disaster responders and the application of the principles across disaster-stricken populations. It is also important to match delivery priorities and appropriate elements of intervention with disaster type, population and response.

Gaps in knowledge and research

For the purposes of this project the value of concepts such as social capital and community resilience lies in their highlighting the need for psychosocial approaches which both focus on collective strategies and go beyond interventions addressing individual mental health. More research is needed around community interventions and how, for example, independently assessed community resources influence the post disaster wellness of constituent populations.

Several researchers have highlighted the gaps in knowledge and practice in terms of enhancing community resilience and social capital and the need for more work to address the practical implications for psychosocial strategies and interventions. Watson et al (2011:285) state that 'because of a lack of consensus on the critical components of community resilience and related interventions, along with the inherent difficulties in implementing and evaluating community-wide programs, there is a paucity of evidence to support their efficacy'. Norris and Stevens (2007:326) also comment on the fact that programmes working directly with communities to enhance their resilience are minimally represented in the literature.

Danieli et al call for more research to explore questions around both individual and community resilience, asking: 'Does increasing resilience decrease/prevent psychopathology? What is the interplay over time of resilience and symptomatology?' They also call for the development of valid measures of the multidimensional communal strengths and resources and community-level measures of traumatisation, resilience and recovery. Only when such measures exist, they say, will we be able to evaluate the efficacy of these efforts and intervene effectively foster and promote resilience and recovery: 'The development of community assessment and intervention tools is an essential component of the future of the field of care. While a few tools are available to assess damage to, and resilience of the community, their paucity presents a major challenge for service providers and researchers alike' (Danieli et al 2005:784).

2. The nine core elements are: local knowledge, community networks and relationships, communication, health, governance and leadership, resources, economic investment, preparedness, and mental outlook (Patel et al, 2017).

Gunderson et al (2012: 580) suggest that identifying populations that lack social capital appears to be an important means in targeting social capital initiatives; however, little research focussed on the impact of the support of the enhancement of social capital has been conducted. Hawkins and Maurer call for further work exploring definitions and the operationalisation of social capital to better understand how it affects individuals and communities as a whole. Key questions include how to maximise social capital while distinguishing positive from negative or counterproductive social capital. Similarly Patel et al (2017) call for more research around forms of social networks that might help in mitigating the effects of a disaster.

SUMMARY

- The promotion of social support, community networks and relationships is essential to protect and support mental health and psychosocial well-being following disaster

- Interventions following CTE should promote a sense of safety, connectedness, calming, hope, and efficacy at every level

- The principles for intervention following mass trauma can be used as a framework for response and recovery to a CTE, including communications

- There is international consensus that interventions should be participative, and provide multilayered support

- Programmes and frameworks should use a stepped care approach, be integrated into large systems and provide a spectrum of services

ADDRESSING PEOPLE'S NEEDS THROUGH FORMAL SUPPORT SERVICES

In addition to informal community relationships and social support networks, organised humanitarian care plays an important part in addressing the impacts of collective trauma events.

This review has highlighted an array of learning and good practice guidance outlining the role for formally organised services in responding to medium and longer term needs of those affected by disaster. This section briefly reviews the specific, diverse, longer term and complex range of needs of those affected and the importance of humanitarian impact assessments as a starting point for addressing them. It refers to key principles identified in the literature related to the organisation, leadership and coordination of post-disaster care and ways of addressing problems and poor practices that provide barriers to accessing support. It also highlights gaps in knowledge, understanding and experience which might be explored through our survey, and which may help to explain why researchers and practitioners have commented on profound issues in accessibility, acceptability and coordination of post disaster care (Norris and Stevens (2007:326).

Responding to diverse impacts and needs

A consistent theme throughout this literature review is the importance of psychosocial strategies following CTE being about much more than psychopathology and trauma services; rather they should focus on holistic processes to facilitate wellbeing, linked with ensuring wider resources, support networks and services are in place. This offers a more comprehensive way of addressing the wide range of impacts and needs following such events.

Addressing diversity in impacts and needs emerges as a key recommendation in various guideline documents. Watson et al point out that because individuals are embedded in a broader familial, interpersonal, and social context, many experts recommend that services should be tailored to meet the needs of as many community members as possible (Watson 2011:487).

Further studies highlight in detail the differential impacts on individuals and communities associated with social vulnerability across the disaster management cycle and the importance of addressing social factors such as age, gender, race, ethnicity, class, health and disability (e.g. Thomas et al (2013), Raphael and Wooding (2006)). Respect for individuals' needs and rights, understanding the diversity of communities, utilising understandable language and developing cultural sensitivity and competence are among good practice principles identified as key to ensuring the best possible care for affected people (Watson, 2011; IASC 2008; Norris and Alegria, 2006). At the same time Watson et al note that ethnocultural factors in communities after disasters have historically been underrepresented in the literature.

Complicated death, complex needs

Included in the literature is research and guidance addressing the impacts and needs of those bereaved through those collective traumatic events involving multiple or mass fatalities. Experiences reflect the prolonged and complex nature of loss and grief following these kinds of 'complicated death' (Eyre, 1998[3]; Dyregrov et al (2014); Neria et al (2007)) which can throw up additional informational, practical, legal and stress-related needs beyond those associated with more ordinary death. This can be due to many external, ongoing complicating factors such as:

- a lack of information concerning the nature of the death(s)
- prolonged disaster victim identification procedures
- disrupted funeral and burial/interment rites
- lack of opportunity to view the body or remains
- continuing threat to emotional safety and security
- ongoing complex criminal and civil investigations and proceedings, such as criminal trials, inquests, public inquiries (which may last for many years).
- lack of resolution and accountability concerning the perpetrator(s)
- relationships with national and other governments.

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3. 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 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 (Eyre, 1998)

Much of the research into grief and bereavement following disasters and CTEs to date has focused only on first order kin and has looked specifically at the prevalence of psychopathology and grief. Research following the 2009 Black Saturday Bushfires in Australia indicated that the loss of friends and community members was found to be predictive of poorer mental health outcomes also (Harms et al, 2015).

Rights-based and victim-focussed approaches

Rights-based and 'victim-focussed' or 'victim-centred' approaches are promoted in a number of guidelines and good practice documents promoting family assistance programmes and victim services following CTE (e.g. Ivankovic et al, 2017; Almeida and Moroz, 2017; ICAO 2013). These reflect international law, regulations and prevailing norms in some jurisdictions; within the European Union (EU) for example the Victims' Rights Directive defines a victim as a natural person who has suffered harm, including physical, mental or emotional harm or economic loss which was directly caused by a criminal offence (Ivankovic et al, 2017:23).
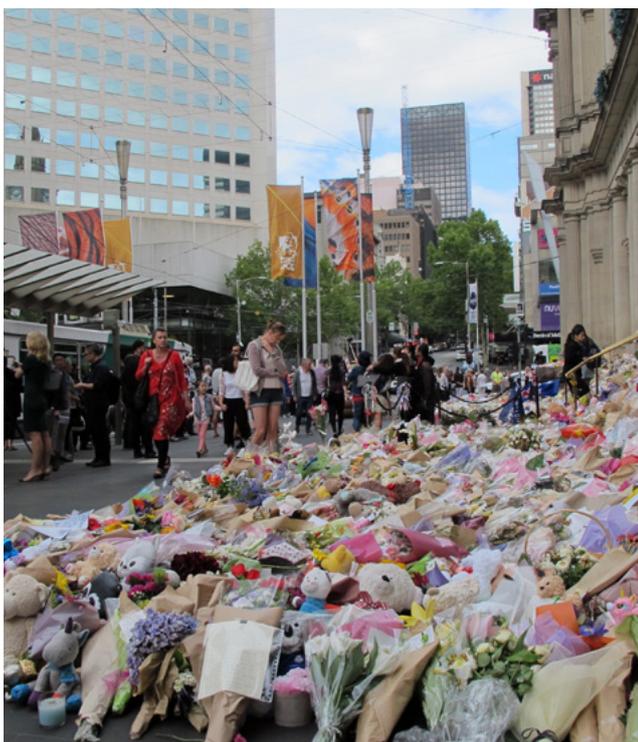
The EU Directive also recognises as victims family members of a person whose death was directly caused by a criminal offence and who have suffered harm because of that person's death. UN Basic Principles go even further than this, recognising as victims those 'immediate family or dependants of the direct victim and persons who have suffered harm in intervening to assist victims in distress or to prevent victimisation.'[4]

To understand the needs of particular groups of affected people it is important to comprehend that their multiple layers. Ivankovic et al (2017) identify a broad set of needs which are common for all people affected by CTEs and fall into five main categories: respect and recognition; support; protection; access to justice; and compensation. The range of needs of victims of terrorism in particular have been at the centre of many recent governmental and public discussions and a significant number of reports and recommendations focus especially on supporting them and addressing their needs (Ivankovic et al, 2017; Almeida & Moroz, 2017; UNODC, 2015; UN 2009; US Dept of Justice (2000)). These reports shed light on the specific nature of needs and how they may be exacerbated by the particular nature and consequences of the crimes endured. Notwithstanding this, the point is also made that additionally the needs of individuals will differ to some extent and therefore good psychosocial support requires an individualised and victim-centred approach.

A summary of commonly identified recommendations for responding to the needs of terrorism victims is presented in Appendix 1. While this identifies some exceptional needs and consequences needs for those affected by terrorism (for example in relation to victims' legal status and certain legal proceedings), it should also be borne in mind that most of these recommendations are just as relevant for those affected by other forms and consequences of CTEs. And, just as in the case of responding to terrorism attacks, the provision of early support following other CTEs can help prevent bigger (and possibly more expensive) problems that victims may face in the future.

4. UN Doc. A/RES/40/34, Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power, 29 November 1985 - http://www.un.org/documents/ga/res/40/a40r034.htm

Secondary victimisation and secondary effects

A common observation across the reports cited in Appendix 1 is that where elements of disaster response are poorly managed the stress levels of people who are already impacted are likely to significantly increase. This leads to recommendations that policies and programmes of support should actively identify and address this. A proactive focus may help mitigate secondary traumatisation, identified as a significant risk for those affected by collective trauma and their consequences: 'Secondary victimization has been defined as victimization that occurs not as a direct result of the criminal act causing harm to the victim but through the response of institutions and individuals to the victim.' (UNODC 2015:14). Secondary victimisation can result from behaviours and attitudes of service providers, government officials or others that are "victim-blaming" or insensitive, whether intentional or not.

Secondary effects may also be experienced by people other than those 'directly' affected , which means that addressing wider community impacts should also be an active priority in assessing and addressing needs. Writers such as Kai Erikson (1995) and Rob Gordon (2004a; 2004b) highlight how, just as individual trauma damages the inner structure of a person, so collective trauma may damage the structures of a community, rupturing social ties and destroying previous sources of support. Others focus on the public health implications of addressing effects such as the increased psychological burden in the general population after a CTE. A 2003 US Consensus Study report, for example, presents a public health strategy which includes recommendations for the training, education and guidelines for service providers. It also addresses matters relating to public health surveillance pre-event and implications and intervention options for the public health infrastructure post-event (Goldfrank et al, 2003).

Of particular concern following terrorist attacks are secondary ripple effects of violence incited by acts of terrorism, with evidence suggesting such acts can lead to increase in hate crime, hate speech and revenge attacks against different social groups. Recent UK research, for example, shows how hate incidents against Muslims in the UK have risen significantly after each terrorist attack not only in the UK but also in the rest of the world (Strommen, 2015 and Faith Matters, 2015). This reflects findings in literature from the USA (Peek, 2011). These attacks include from hate speech online, revenge attacks, targeted property crimes and hate crime against minority groups. The 2017 European Parliament Report states that whilst these attacks tend to focus on minorities that can in one way or another be linked to the 'group' the attacks claim to represent, an increase in hate incidents are found towards a wide range of minority groups. For example, an increase in hate crime against the Jewish community and refugees has been recorded in the aftermath of terrorist attacks (Ivankovic, 2017:25) and there are documented examples where fringe religious groups and commentators have blamed disasters on the LGBTIQ community, attributing them as a form of punishment (Dominey Howes, Gorman-Murray and McKinnon, 2014). These examples show how the wider community faces the consequences of terrorism either directly or indirectly through the ripple effects of violence.

For these reasons, in addition to timely approaches aimed at prevention and protection, ongoing and effective strategic responses aimed at identifying and addressing broader community impacts are essential. 'Whilst some governments tend to publicly react to terrorist attacks by promoting civilians to 'keep calm and carry on' this response should be complemented by a recognition and vigilance for the fear, social or psychological problems that the general population might develop in the wake of an attack' (Ivankovic, 2017:25-26).

Ongoing humanitarian impact assessments

Initial and continuing impact assessments are important for gaining an understanding of the range of needs and individuals affected by any CTE and guidance recommends these should function as the basis of both early responses and longer term psychosocial support strategies (e.g. IASC 2007).

To understand exactly what humanitarian assistance is required it is important to map out who is affected and how the emergency has affected them. Assessments should include identifying vulnerable people that may be disproportionately affected and the impacts to the broader community.

This reflects the fact that vulnerability and impacts can be associated with or caused not only by the current traumatic event(s), but may also include pre-existing (pre-emergency) psychological or social problems, and/or those problems induced by the nature, impact or manner of support provided (IASC 2007:2). This includes those aspects of secondary victimisation referred to above. Good practice guidance suggests simple, standard formats for assessing psychosocial needs and for mobilising resources can assist greatly in providing an adequate organisational response, avoiding duplications in output (e.g. Seynaeve, 2001). Charting the general situation, resources deployed, issues arising and priorities will all aid strategic decision-making.

A good example of this approach is the London Resilience Humanitarian Assistance Framework which provides a template to assist in gathering information to aid understanding of impacts and steps that may need to be taken to mitigate them. Such guidance emphasises that during an incident the type of humanitarian assistance needed will change and advises the assessment may need to be refreshed to ensure strategic decision-makers are working with the most up-to-date and credible information.

In keeping with this approach the IASC emphasises the importance of assessments being coordinated, relevant to psychosocial support inclusive of and beyond mental health, developmental, and

used as a resource and guide for planning (2007). They go further in highlighting the importance of participative approaches in situational assessments being achieved through community engagement in ongoing monitoring activities and evaluation reviews. In practice this means drawing on the knowledge, experience and feedback of local people, affected groups and service users as part of a longer term ongoing process of reflection, learning, service review and adaption.

The value of approaches like that of the IASC lies in their acknowledging and operationalising the value of community-based knowledge and expertise as part of assessment processes. It includes identifying those existing resources of psychosocial well-being amongst individuals and community actors (e.g. community workers, religious leaders or counsellors). This is in addition to drawing on those resources pre-identified by organisational partners. Both approaches have value and represent a departure from relying solely on formal service providers or a top-down approach which can sometimes be the presumptive starting (and endpoint) for assessment, service design and implementation within emergency planning processes.

More participative approaches to assessment and service design build on collaborative principles by formally recognising and listening to those affected as the key to gaining an understanding of what is needed. This has been identified as an area where more research is needed to guide the implementation of disaster mental health (and other) services that are acceptable and feasible for both recipients and providers (Watson et al, 2011:490): "The bottom line is that in the immediate aftermath of trauma, professionals should take their lead from the survivors and provide the help they want, rather than tell survivors how they will get better" (McNally et al 2003:68).

In the context of CTE and the kinds of formal service provision being described here, drawing on people's experiences of the emergency in the widest sense including for example the public's perceptions of events and their importance, perceived causes, expected consequences, and service provision) might

be achieved through the use of online feedback mechanisms such as social media, online surveys and discussion forums, outreach services and other community development activities.

Strategic leadership and organisation

Leadership of an organised and coordinated overall psychosocial strategy has long been highlighted in the literature as an important element for achieving effective and wide ranging support strategies following a CTE. Practitioner focussed resources identify the complex and often daunting role of strong, positive leadership during and after CTEs (McNaughton, Wills and Lallemant 2015). The 2001 European policy paper outlining guidelines on psychosocial stresses the importance of being clear about who is leading the organisation of psychosocial support, and also emphasises that psychosocial support should be clearly linked to other strategic working groups within wider response and recovery frameworks (Seynaeve, 2001). More generally, ensuring clear front-line leadership at the local level during a crisis continues to be identified as a main theme across literature focussing on factors promoting community resilience (Patel, 2017).

In a knowledge review about the contribution of social care to emergency response and recovery the UK's Social Care Institute for Excellence (SCIE) has recognised a role for statutory social care agencies taking the strategic lead in planning for and responding to humanitarian needs (Child et al, 2008). Regardless of which agency is identified as having lead responsibility, which will likely vary according to local circumstances, the extent to which responsibility is activated in practice following a CTE is crucial and not always a given. In the UK again, for example, while recommending that directors of social care or social work services should assume responsibility for the planning and coordination of practical and emotional support, in practice the SCIE review highlighted inconsistency in levels of preparedness, readiness and priority (Child et al, 2008:8). This was due in part to the lack of legislated mandate. This reinforces how important local

buy-in and political support at the planning stage is, though it is also not always guaranteed (Eyre, 2006: 81). Similarly, it is not always guaranteed that strategic leaders for managing the local or regional coordination of psychosocial support activities are pre-identified, even where local guidance advises that they should be (Eyre 2007). The need for an agency or agencies to be mandated with lead responsibility has also been emphasised with regard to for implementing and coordinating national policies and practices, in relation for example to the protection and support of victims of terrorism (UNODC 2015:17).

While discussing a systematic approach to disaster psychosocial response, Cox and Danford (2014) identify competency in disaster psychosocial programme leadership as a distinct category within a competency framework, adaptable for various social contexts. In line with this and linking leadership to best practice, Gunderson et al state that the acknowledgment, acceptance, and integration of evidence-informed intervention principles (safety, calming, efficacy, connectedness, and hope) into leaders' efforts is critical for achieving appropriate policy and practice (2012:576). Helpful experience and reflection for leaders include those collated by McNaughton, Wills and Lallemant in gathering lessons from across the world and offering principled and practical guidance for disaster recovery leaders (2015).

Multiagency coordination and partnership working

The need for efficient coordination and integration of disaster response services has been demonstrated following many CTEs. An international symposium in 2013 exposed examples of this and implications for good practice. It brought together international researchers and clinicians to share their recent lessons in psychosocial responses to disaster (Reifels, 2013). Presenters agreed that large-scale psychosocial disaster responses require coordinated efforts to address multiple competing demands in chaotic circumstances. These demands include the need to ensure the continuity of existing health services, establish enhanced psychosocial services for the

disaster-affected population, coordinate response agencies, integrate international resources, and monitor population disaster impacts and outcomes of response services.

International experiences and learning have also reinforced the importance of having in place designated lead agencies with clear lines of accountability and multi-agency steering groups to further facilitate the integration of psychosocial response and recovery activities (Danieli et al, 2005). According to the literature key components of good practice include the role of multidisciplinary teams which extend beyond psychologists in the provision of multidimensional care, from low intensity support through to specialised high-intensity interventions (Reifels et al, 2013). Governmental agencies, civil society, community groups and non-governmental organizations have all been highlighted as having roles to play in the provision of this kind of assistance and services following collective trauma events and approaches focussing on effective partnership across organisations and types of service providers are emphasised (Watson et al, 2011). To achieve this in practice, pre-planning, training and formalised agreements such as memoranda of understanding are strongly recommended (e.g. UNDOC, 2015:17).

Despite clarity around such principles and aspirations there remain gaps in knowledge and practical

challenges to achieving these principles in practice. In part this reflects the fact that each disaster event produces unique impacts and challenges that require the tailoring of psychosocial responses to the existing community, service systems, and disaster context. The IASC produced its guidance and checklist in order to address the absence of a multi-sectoral, inter-agency framework that enables effective coordination and clarifies how different approaches to mental health and psychosocial support complement one another (IASC, 2008). Still, however, Refiels et al comment that little is known about implementation frameworks that facilitate the translation of available support strategies for disaster-affected populations (2013).

Further challenges include wide variation in the numbers, resourcing and coordination of personnel and agencies involved following particular CTEs (UNDOC 2015:17), barriers to accessing care (Reifels et al, 2013) and discontinuity across services and phases. For these reasons it is frequently stressed that preparation should not be limited to short term phases of emergency response, but should also consider the medium and longer-term psychosocial needs of those involved, including carefully scoped transitional arrangements. Danieli et al (2005:786) make the point that most societies find it extremely hard to invest resources based on long-term considerations and instead decide to spend resources only when faced with concrete challenges. Contributors across this edited International Handbook on the Trauma of Terrorism demonstrated how collaboration among care agencies at all levels develops largely in response to threats to safety and mainly after actual disasters; thus 'a major challenge for policymakers is to design and put into place realisable and sustainable response mechanisms in advance of the need for them' (2005:783).

Still, state Danieli et al, the requirement exists for interrelated elements of an integrative, seamless service framework, and a need to build ongoing sustainable programmes that ensure responsiveness and response-ability from a solid foundation:- 'The timeline is to solidify *before,* keep flexible enough to response to various forms *during* incidents ...and (re) adjust the programmes and the responders *after*' (2005:782-3).

Continuity in service planning and provision

A common pitfall is failure to appreciate the importance of continuity in the planning and provision of support after a CTE (Eyre, 2007). Addressing continuity is a logical starting point for understanding individual and organisational responses after disaster and should be central to the planning and structuring of psychosocial support. In terms of the meaning and implications of continuity, various studies show that people do not abandon their social histories when confronted with adversity – 'and organisational systems reflect it' (Drabek 1986:158). One implication of this is that those organisations are well prepared, organised and resilient before disaster are more likely to reflect similar qualities during and after disaster response.

A second example of the need for continuity relates to the fact that at times of uncertainty (such as during 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 psychosocial support does not incorporate or engage with familiar and sustained elements of community-based support, it may be more likely to fail (van Ommeran et al, 2005). This is why sufficient account should be taken of the significance of embracing elements of continuity.

For these reasons writers recommend that post disaster services should adhere closely to normal practice and use established 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' (Gibson 1994:143). Seynaeve (2001) makes the point that mobilising already existing resources and services which deal with small-scale emergencies on a daily basis is also more cost-effective than the creation of a separate bespoke group of staff and resources.

Seynaeve goes on to suggest that in the event of a major emergency capacity to respond can be easily increased (if there has been prior networking and specific training). Experience however does not always bear this out; indeed Gibson refers to the challenges arising from the redeployment of staff away from disaster-related services; for this reason she emphasises that 'continuity of helper is most desirable' (Gibson, 1994:141). This is a principle reinforced by caseworker and 'victim navigator' approaches which are also promoted as a way of preventing service users falling through gaps in service provision. (Dinnisman and Barker, (2016); Ivankovic, 2017:111). Ivankovic outlines the further benefit of such continuity for service users in terms of limiting the time it takes to establish familiarity and trust between support worker and victim and links this to the importance of ensuring, proper transition arrangements are in place with victims being notified as early as possible (2017:111).

Addressing barriers in access to care

In addition to addressing coordination and integration studies have also discussed the need to proactively address barriers in access to care following CTEs. Since barriers in the access to and utilisation of mental health care tend to be amplified following disaster (Elhai and Ford, 2009; Rodriguez and Kohn, 2008), it has been argued that psychosocial disaster responses need to prevent these barriers in an effort to reach disaster victims (Gibson et al, 2006; Watson et al, 2011).

After the London bombings in 2005 notable barriers to programme access included inflexible existing referral pathways, limited programme familiarity among family doctors, low programme usage among individuals approached by third parties, and challenges to survivor identification (such as institutional barriers to disclosing who had been affected) (Reifels, 2013). A significant surge in demand, particularly for psychological support services, can be anticipated following CTEs and this poses additional challenges where ordinary mental health and other support services for those affected by single traumatic events are already stretched. Even in ordinary time research on homicide-related services in the UK for example has highlighted limitations in provision and the fact that only a patchwork of trauma support is available across the country; on a routine basis the demand for specialist trauma services simply outstrips supply (Casey, 2011).

There is common agreement in good practice guidelines on the need for robust referral arrangements so that those victims who need acute psychosocial help can be picked up as part of a good system of relief (Te Brake and Duckers, 2013). However there is much evidence highlighting the particular difficulties related to referral mechanisms which themselves can frequently act as barriers to accessing medium and longer term psychosocial care. The response to a number of CTEs has also highlighted barriers such as the identification of survivors as well as limitations of existing referral pathways, and that these are exacerbated where there may also be destroyed infrastructure and other difficulties in accessing appropriate care (Reifels, 2013).

In order to achieve more effective referral pathways phased pathways of support have been suggested. A number of initiatives in the UK are currently focussing on the development of such referral pathways to address the needs of those directly and indirectly affected by CTEs with a view to clarifying entitlements, scoping support services and consolidating arrangements for ensuring those affected get the right support at the right time. An example of this is NHS London's Pathway for witnesses following a terrorist attack (NHS, 2017).

In sum a key theme in this review has been the need for formally organised and coordinated support, supported by good leadership, coordination and referral mechanisms. This will help to reach across and beyond health and social services and into wider community perspectives, wellbeing resources and services. It also addresses both the types of needs that go beyond clinical perspectives and psychopathological treatment (Danieli et al, 2005:781) and the part to be played by the wide range of organisations and sectors offering support and services. In two reports drawing together recent lessons following various terrorist attacks Victim Support recommend that a pathway of support should be mapped out and agreed by all of the agencies involved in assisting them and clarifying what services should be provided by whom and at what point (Barker and Dinnisman 2016; Almeida and Moroz, 2017).

SUMMARY

- Following a CTE psychosocial support services should address a broad range of practical, emotional, financial and other welfare-related needs

- Psychosocial support needs to extend beyond clinical perspectives and psychopathological treatment

- Key principles include rights-based and 'victim-focussed' or 'victim-centred' approaches

- Good practice includes pre-planned, well-led, coordinated, multiagency support services

- Risks to good practice include issues in accessibility, availability and coordination of post disaster care

- It is important that short, medium and long term psychosocial aspects of CTEs are included in planning

- Organisational approaches to the consideration of who has been affected will have service access implications for those who require support

MAKING SENSE OF AND LEARNING FROM CTE

Meaning making is an important aspect of coping and recovery following CTE and is addressed in this section. Within psychological research the importance of meaning and meaning making has emerged across several different studies examining ways of addressing highly stressful life experiences. Indeed Harris et al refer to how, according to various theorists, the notion of "trauma" itself is defined in relation to meaning systems being overwhelmed as well as individuals' coping resources (Harris et al, 2013). They outline how theorists from varying perspectives have considered meaning making in relation to individuals' efforts to create a comprehensible, integrated, ordered worldview that adaptively incorporates the experience of trauma as an essential aspect in recovery.

In 2010 Park proposed a meaning making model to integrate some of the common features from a number of current theoretical perspectives. Her model distinguishes between the constructs of global and situational meaning. 'Global meaning' here refers to individuals' general orienting systems consisting of beliefs, goals, and individuals' subjective feelings as well as self-views. Global beliefs comprise broad views regarding justice, control, predictability, coherence, and so on. 'Situational meaning' refers to meaning in the context of a particular environmental encounter. Situational meaning thus begins with the occurrence of a potentially stressful event and describes an ongoing set of processes and outcomes, including assignment of meaning to the event (appraised meaning), determination of discrepancies between appraised and global meaning, meaning making, meanings made, and adjustment to the event.

Meaning making processes following a traumatic event include searching for comprehensibility, as here described:

'Meaning is an effort to understand the event: why it happened and what impact it has had. The search for meaning attempts to answer the question, What is the significance of the event? Meaning is exemplified by, but not exclusively determined by, the results of an attributional search that answers the question, What caused the event to happen? . . . Meaning is also reflected in the answer to the question, What does my life mean now?' (Taylor, 1983:1161 cited by Park, 2010:260).

Within the literature on this subject the outcomes of meaning making processes - 'meanings made' - include a sense of having "made sense"; acceptance; causal understanding; integration of the stressful experience into identity; and post traumatic growth. In addition, meaning making is widely (but not universally) considered essential for adjusting to stressful events (Park, 2010:261).

Research on meaning making is predominantly psychological in focus but can be related to those aspects of community resilience research that focus on mental outlook[5], defined across the community resilience literature in terms of attitudes, feelings and views when facing the uncertainty that typically occurs after a disaster or when contemplating a future one (Patel et al, 2017). Notions such as hope and acceptance (also discussed within meaning making studies) commonly feature among identified aspects of resilience and, as started earlier, interventions that promote community resilience appear to hold considerable promise for promoting the five evidence informed principles of psychosocial intervention (safety, calmness, hope, efficacy and connectedness') in the aftermath of disaster' (Norris and Stevens, 2007:327).

Writers such as Judith Herman make the link between individual experiences of trauma and recovery and the need to connect with others: 'In the aftermath of traumatic life events, survivors are highly vulnerable. Their sense of self has been shattered. That sense can be rebuilt only as it was built initially, in connection with others' (1997:61). Herman's work highlights the role of the social and the collective in individual meaning making: 'Sharing the traumatic experience with others is a precondition for the restitution of a sense of a meaningful world. In this process, the survivor seeks assistance not only from those closest to her but also from the wider community. The response of the community has a powerful influence on the ultimate resolution of the trauma.'(1997:70).

Meaning making is an area where further research is needed. Commenting for example on the significant gap between the rich but abstract theories and empirical tests of them, Park calls for more work examining the way studies conceptualise and measure both meaning making efforts and meaning made. She asserts that we need 'to better understand what meaning making is and then ask for whom, and under what circumstances, are particular types of meaning making and meaning made helpful and why?' (2010:293). In relation to the focus of the present project, therefore, relevant questions for future research might include defining measurable

outcomes for social activities and psychosocial interventions and the exact role they may play in enhancing collective experiences and processes of meaning making and recovery-related outcomes.

Acknowledging the importance of meaning making is compatible with promoting evidence-based psychosocial principles. Enhancing people's sense of safety and calmness, for example, may contribute to the re-establishment of global beliefs relating to justice, control, predictability, coherence and so on). Psychosocial strategies which also positively contribute to situational meaning can help people make sense of particular events by enabling them to comprehend, assimilate or accommodate experiences.

Three examples of activities and processes, which have also been linked to the fulfilment of fundamental needs and meaning making for those affected by CTES, are detailed below; these are the provision of information (through initial and ongoing communication, and being included in contacts lists), participating in acts and rituals around memorialisation, and recourse and access to procedures around legal justice and learning.

Recognition, respect and acknowledgement

Meaning making and sense making studies remind us of the emotional and symbolic dimensions of post-trauma environments and that the purpose and significance of psychosocial strategies are more than purely practical. Respect and recognition for example - achieved through social, political and legal acts of acknowledgement - have been identified as especially important for trauma victims.

In relation to terrorism, for example, one of the most important needs voiced by victims is for recognition: 'Social acknowledgment in general is important to victims, with victims' recovery being connected to the victim's experience of positive reactions from society that show appreciation for the victim's unique state and acknowledge the victim's current difficult situation...The reaction of the public, the media, and politicians' public statements are important

5. (Patel et al's review refer to mental outlook as a conceptually different theme to mental health, the latter dealing with well-being while the former deals with attitudes towards uncertainty).

mechanisms for recognising victims of terrorism as well as acknowledging their status as victims and the harm caused. (Ivankovic et al, 2017:28-9).

Recognition, respect and formal acknowledgement are important symbolic functions achieved not only through psychosocial strategies in general, but also specifically in the manner in which they are implemented, that is to say ethically, appropriately, and in keeping with evidence-informed principles.

The importance of and access to information

Making sense of a CTE starts from the moment an event begins to be experienced or becomes breaking news, and meaning making takes on an explicit practical purpose in the initial phases of disaster. The positive and negative effects of media and social media has been the subject of much reflection and analysis and there continues to be debate about the ethics and appropriateness of sharing graphic details and images given their potential traumatising effects on families, the public and journalists (see e.g. Ritchin, 2014; Dart, 2014).

Having access to early, accurate and regularly updated information helps inform the public's understanding about what is happening or has happened and choice and control around actions that may promote safety, calm and connectedness. Hence Hobfoll et al advocate a proactive role for information-giving activities (via the media, community outreach and psychoeducation) among public health, individual and group measures (2007).

Experience has shown that information is a vital need for people affected by a major emergency, particularly where loved ones may be involved. Knowing what happened to a loved one is a pressing, immediate and almost vital need that must be attended to in an appropriate way. Separation from family members can lead to long term mental health issues (Richardson et al, 2017) Communication of information about the actual situation and perspectives, especially of injured victims, also remains a priority in the later stages. Providing affected people with accurate, factual information

on the incident itself is essential in assisting them with coming to terms with what has happened (Seynaeve, 2001).

In the medium and longer term, satisfying the need for ongoing information, especially by those directly affected, has been specifically underlined and described as a fundamental right: 'prompt, accurate and consistent information is the cornerstone of any adequate support for victims, and as such needs to be ensured immediately .... and for as long as it takes (Ivankovic 2017:130). Victim Support's 2016 report supports this stating that it is not only the nature of how someone has been affected that may determine the support they receive, but the simple fact of what information they have access to. They say that though it may seem self-evident, providing information alone is not enough. It must be easily accessible, consistent across agencies and delivery organisations, and reliable. 'As we have seen, failure to provide survivors and bereaved families with this information can cause them to feel unsupported and distressed'. (Barker and Dinnisman 2016: 47-48).

Communication and psychosocial strategies

Given the significance of information it is fundamentally important to have effective data gathering and management arrangements in order to ensure that communication strategies and psychosocial support strategies with target groups are effective; if for example bereaved individuals or survivors are not included on contacts lists, or those lists are not available to agencies needing to pass on update, individuals become effectively excluded from information and all that having it entails, enables and facilitates. This has been the experience following previous CTEs and a number of reports comment on this (e.g. NAO 2006; Cabinet Office 2007). Seynaeve devotes detailed attention to general principles concerning information management and psychosocial interventions in situations of mass emergency highlighting how all the processes collection, registration, processing, assessment, verification, storage and communication of data should observe professional rules and standards.

The need for greater awareness and understanding of the management of information such as personal data was identified as fundamental areas of learning following UK responses to the Asian Tsunami (2004) and further flagged up in the Government's report on lessons from the 7 July 2005 attacks. It became apparent that in some parts of the emergency response data protection requirements were either misinterpreted or over-zealously applied leading to individuals failing to be recognised, included on contacts lists and thereby able to benefit from information and communication channels. Subsequent reports indicated that this experience was not unique. It has led to the issuing of tailored guidance for the emergency community to dispel some of the myths and provide a useful resource to inform future emergency planning, response and recovery (e.g. Cabinet Office (2007); ADPH (2018)). Variation in understanding, interpretation and data sharing protocols is likely to remain an area of risk however, not least given changes in technology around the management of data, and this may therefore be a theme worth exploring through our study.

The use of mass media has been highlighted as a key tool for both informing the public during and after CTEs and as a means for imparting psychoeducative messages and psychological first aid. The role of social media by trusted agencies during and in the days after the Boston bombing has been cited as a positive example of the role social media can play (Davis et al, 2014). The use of official communication channels and public messaging by trusted government officials during and after disasters may help support response and recovery initiatives. Public confidence in leaders along with accurate and effective communications to the public about risks and appropriate actions can ameliorate anxiety and fear in communities (Orner et al, 2006). *More broadly effective communication*, whether *risk* or *crisis communication*, features significantly within community resilience literature as being important in helping communities articulate, coordinate and understand the risk and impact of disasters (Patel et al, 2017).

Compassionate leadership and grief leadership have also been identified as positive models during collective trauma events, and linked to the ways in which communication strategies enable people to feel heard and that the emotions and needs of their community are understood. Research following the 2009 bushfires, for example, linked communication with caring as two critical factors in disaster recovery: 'Clear and regular communication was essential for making informed decisions and a caring manner in the delivery of services and support was repeatedly reported as having a positive influence on recovery' (Gibbs et al, 2016: p18).

The rapid rise and advances in technologies such as social media necessitates more research on the relationship between new forms of media, trauma and recovery and psychosocial interventions Writers warn of the potential harm as well as value engendered through the use of such media (Norris 2007:323) and call for investigations into the proliferation of self-help education interventions with disaster survivors (Watson et al, 2011:488; Danieli et al, 2005). Some research has focussed on the role and value of online support groups (e.g. White and Dorman, 2001; Potts, 2005; Griffiths et al, 2012), though these tend to focus on support for depression and other illnesses as opposed to collective trauma events as discussed here.

6. http://www.stromloforestpark.com.au/facilities/bush-fire-memorial

The role of ritual and memorials

Much has been written the role of post-disaster ritual and memorials in making sense of collective trauma and enabling expressions of grief and mourning. Forms of ritual, expression and commemoration include spontaneous acts and tributes, online and physical books of condolence, planned periods of silence, the organisation and conduct of official memorial services, anniversary events and permanent memorials (Australian Red Cross, 2018).

Despite the predictions of some commentators in the past, post disaster ritual and remembrance remains vibrant in societies across the world. The forces of globalisation and technological advances are changing both the ways in which people experience disaster and the ways in which they respond to and ritualise after them. The growth in world travel and digital communications means most disasters have an international dimension such that communities of more than one country are involved in grief and mourning rituals in the aftermath. (Little, 1998)

Post-disaster rituals, in so far as they reflect and endorse a sense of family and community, can express and reinforcing a shared sense of meaning and understanding, even if that sense of order and meaning has been temporarily suspended at a time of shock and loss (Eyre, 2005). When a fundamental sense of safety and security feels threatened through collective tragedy the potential value of such rituals in re-establishing feelings of control, belonging and social solidarity within and beyond one's immediate community is understandable.

Spontaneous and organised rituals and memorial processes also reinforce public acknowledgment and recognition over time, offering a sense of social acceptance, social solidarity and social support for individuals and communities who are suffering. They may also be used to explicitly acknowledge the diverse impact of a collective tragedy. A recent example of this was the national memorial service which took place six months after the Grenfell Tower Fire in London that took over 70 lives in June, 2017. In consultation with community representatives the service was designed to remember those who died, to show solidarity with the bereaved and survivors, and to give thanks for everyone who assisted on the ground at the time of the tragedy and since, including emergency services, the recovery team, community response, public support, and volunteers. Services such as this can reflect and represent the connectedness between the living and the recently deceased, and symbolise an important continuity between the past, present and future.

Temporary and permanent memorials

The spontaneous expression of grief, evidenced in tributes, messages and acts of condolence, temporary memorials and shrines, is both common and predictable following collective traumatic events (Eyre, 2005). Within hours of news of a collective tragedy a sea of flowers, messages, soft toys and memorabilia can begin to mount. In view of this temporary memorial management has become an important aspect of emergency planning, including consideration of the sensitivities around removal, storage and archiving, and international practitioners are beginning to network and share learning around the implications of this for historical, artistic and museological purposes.

This collation of shared experiences among researchers and practitioners will help establish a body of evidence for enhancing understanding of this important subject and its connections with psychosocial response and recovery. Helpful psychosocial guidelines for temporary memorial management have recently made an important start, having been prepared for the Australian Red Cross by Shona Whitton (2018a) on the basis of a Churchill Fellowship which explored the implications of temporary and permanent memorials for psychosocial recovery (Whitton, 2018b). The guidelines include good management principles focussing on the importance of being inclusive, supportive, respectful and consultative during the management, removals, storage and preservation of temporary memorials.

The importance of continuing to remember events, and long after temporary memorials have gone, is illustrated post-disaster in the erection and maintenance of permanent memorials following collective tragedy (Richardson 2010).

CASE STUDY

The 2003 Bushfires Memorial consultation process

A good example of community engagement in the planning of a permanent memorial is the consultation framework established in Canberra following the Australian bushfires in January 2003. The bushfires destroyed lives, homes, pets and possessions. The notion of a permanent memorial was recognised as important for acknowledging a significant event in the history of the region and marking a milestone in people's lives. Consequently a Bushfire Consultation Advisory Committee comprising community and government members was established to provide guidance on the project and assist in the consultation process with the broader community.

During an extensive community consultation process ACT residents were asked whether they wanted a memorial and, if so, what should the memorial convey and where should it be located. The community endorsed the concept of the memorial, and indicated that the memorial should:

- be a simple natural and beautiful place which encourages a sense of peace and reflection;
- be inclusive and accessible to the whole community;
- be enduring and have the capacity to grow over time; and
- enable the community to participate by contributing objects with personal meaning.

In conceiving the design, commissioned artists stated that: "Contributions by the community will form an integral part of the final memorial which will gain its 'heart' from community involvement and from the ongoing use of the setting."   Over two weekends in April and May 2005, the artists invited people from the ACT region to provide contributions for the memorial. They received more than 500 images from 80 families and individuals and more than 160 people provided inscriptions to be used on bricks for the curved entry wall to the memorial.

The memorial that evolved through this design and development process takes visitors on a journey from the day of the fire, through the process of recovery, to the honouring of memory. The symbolism captured and displayed in Stromlo Forest Park acknowledges the impact of the bushfires, marks the process of recovery, and gives thanks to the many organisations and individuals who played crucial roles in the fire fighting and recovery efforts. Over time, the memorial has settled into a park-like setting (http://www.stromloforestpark.com.au/facilities/bush-fire-memorial).

Participation and consultation in commemorative processes

Opportunities to participate in ritual acts and memorials are important following collective trauma and increased media coverage has increased involvement in acts of remembrance and commemoration. Furthermore advances in technology, including increasing use of the internet and social media, as well as the development of more consultative approaches, are giving greater control over the nature, design and focus of rituals and commemoration to those directly and indirectly affected by disaster (Eyre, 2005).

The opportunity to participate in such acts and rituals may reflect and/or contribute to levels of social capital as well as fulfilling functions associated with the five psychosocial intervention principles discussed in this review. Indeed Hobfoll et al refer to 'meaning making' and the promotion of hope in relation to memorialisation (2007:304). As well as connecting people collective gatherings and ritual activities also provide opportunities for community outreach and psychoeducation, including messaging around safety and calming, while the principles of self and community efficacy are promoted through active community engagement and participation. For these reasons those with direct experience of disaster have stressed the value of opportunities for bereaved people and survivors to participate in group consultations around memorialisation (Eyre and Dix, 2014).

In keeping with principles of acknowledgement, respect, and efficacy it is increasingly recognised that the bereaved and survivors and local communities are key stakeholders to be consulted in planning the design and development of permanent memorials commemorating disaster. The Bushfire memorial consultation process, as detailed in the case study below, is an example of this[6].

This is not always a given however, and in such circumstances plans and gestures may risk causing offence, distress or even extreme upset (as in the case of memorial plans for MH370 (Lloyd, 2018) and Utoya (Aouf, 2017). Of course, the greater the number of consultees, the greater the potential for disagreement and dissent and there are likely to be restrictions on what might be practical and feasible in the design, cost and location of a permanent memorial. Experience suggests good practice involves enabling consultation and participation within the boundaries of possibility and practicality and communicating openly and honestly with stakeholders given the sensitivity and significance of all aspects of the memorialisation process.

Psychosocial strategies: place, space and time

When collective tragedy occurs at, or is associated with, specific geographical sites those places and spaces can become especially important physical and symbolic locations in the days after. Crime scenes may be cordoned off for forensic purposes but marking these places off may also reflect a sense of the 'sacred' - that is to say those places where people have died are temporarily, at least, set apart, treated with special respect, protected and subject to privileged and purposeful access.

In this context an important aspect of psychosocial support is the facilitation of site visits, an important aspect of grieving for bereaved families and survivors which have become the expected norm in many societies. It has been recognised that visits by the bereaved and survivors to key sites are extremely important after an event, both for making sense of events, showing respect and for grieving and that visits should be carefully facilitated by those coordinating and providing psychosocial support as part of the grieving process (Eyre, 2006). Affording those directly affected a private opportunity to visit closed sites before they are reopened again to the public not only shows respect and recognition but also helps mark a transition in the identification of the space for the wider public. Ahead of the reopening of Manchester Arena in September 2017, for example, families were offered a private visit to the venue where four months previously a terrorist attack had claimed 22 lives (BBC News, September 8, 2017).

Reclaiming spaces

The symbolic meaning and ongoing association of places with collective trauma, and particularly with multiple death, explains why in the longer term there can be powerful social, symbolic and political significance attached to questions around transition and returns to 'normality', and later on around the nature and location of permanent memorials (as recently illustrated in the cancellation of memorial plans at the site of the Utoya tragedy (Aouf, 2017)).

The negotiated use of spaces and places associated with acts of terrorism in particular reflects a symbolic relationship between a range of stakeholders, including local communities and governments (Heath-Kelly, 2016). Highlighting the practical implications of this, Coaffee refers to the Australian government's new strategy for protecting crowded places from terrorism and the symbolic significance of place: 'A resilient crowded place has trusted relationships with government, other crowded places, and the public. It has access to accurate, contemporary threat information and has a means of translating this threat information into effective, proportionate protective security measures commensurate with the level of risk they face' (Coaffee, 2017).

Coaffee challenges the aesthetics of security bollards and notes public reactions and responses including attempts at beautifying bollards as a form

of protest in Melbourne. He also makes the broader point that counter-terrorism measures deployed in crowded public places must seek to balance security effectiveness with social and political acceptability. Similarly the choice to either return places and spaces to 'normality' following acts of terrorism (in defiance of perpetrators, as an act of deliberately forgetting) or, in contrast, to permanently marking a site or changing the function of a place (as acts of remembering/never forgetting) may reflect a fraught process of negotiation between stakeholders, holding divergent and conflicting, emotionally significant views. However, deciding what role those directly affected can or should have in such decision-making often reflects political agendas as much as, or rather than, psychosocial considerations.

The importance of and access to justice

A final example of activities and processes linked to the fulfilment of fundamental needs and meaning making for those affected by CTEs are those giving access to procedures around legal justice and learning.

The potentially damaging effects of traumatic events can include their negative impact on people's sense of meaning, justice, and order. Many trauma survivors struggle in the face of shattered assumptions about justice in the world due to the ways in which they have either been exposed to traumatic events or treated during the post-traumatic aftermath, or both (Hobfoll et al, 2007:285). It is on this basis that having recourse and access to legal systems and processes of justice has been identified in several reports as a fundamental need for those affected by collective traumatic events involving acts of crime (see Table 2 - page 35).

With regard to terrorism, it has earlier been stated that formal recognition of victim status has been highlighted as an important pre-condition of acknowledgement as well as formal recognition. This includes formal recognition through victims' involvement in criminal proceedings, though this status is not always guaranteed (Ivankovic et al,

2017). According to Ivankovic et al victims need for access to justice can be summarised as wanting to see justice is done(outcome focus/distributive justice) and wanting to be confident about how it is achieved (procedural justice). It can cover a wide variety of issues, such as accessibility of court processes, availability of adequate legal representation in criminal trials, access to more informal legal processes (such as penal mediation) and the right to review a decision on whether or not to prosecute the offender. In keeping with principles of efficacy, building trust and hopefulness, access to justice is also about participation and acknowledgement of victims' rights: 'Victims need to get full access to and be able to participate in the justice system, which encompasses the right to be heard' (Ivankovic et al 2017:27).

Legal processes and pathways to justice have implications not only for individuals seeking personal access to meaning, justice and resolution but for those wider societies in which collective trauma events occur and have an impact. Herman highlights this in the way she emphasises the importance of public forums and processes as a starting point for recovery, on both the individual and collective level after mass trauma - 'Restoring a sense of social community requires a public forum where victims can speak their truth and their suffering can be formally acknowledged' (1997:242).

As Herman's quote suggests recovery requires a sense of social community in which people feel supported in looking back and looking forward. She refers to historical events such as the Truth and Reconciliation Commission in South Africa, but her writing has implications for other types of post-collective trauma event. As families' participation in the creation of the Commission into the terrorist events on September 11[7] and other post-disaster inquiries illustrate, it is important to stress that moving forward from disaster physically, emotionally and symbolically is about more than acknowledging suffering and giving those most affected an opportunity to tell their stories, remember and commemorate. It is also about establishing and actively participating in legal and political processes to address objectively, openly and honestly the

7. http://govinfo.library.unt.edu/911/family/index.htm

CASE STUDY

EQ Recovery Learning website

In NZ the government has set up an EQ Recovery Learning website to collect and share relevant insights and experiences that will equip leaders and communities involved in disaster recovery and complex challenges. The process includes a participative approach by capturing experiences and stories from those directly involved in dealing with the Canterbury earthquake, 2010, and its aftermath as individuals, volunteers, neighbours, and communities as well as formal responders.

The importance of community engagement and involvement has been one of the recurrent themes captured through this feedback and learning process and is an approach reflected in the online platform itself in its methodology for gathering learning. The website has been designed to function both as a tool and as a companion in the way it consults with and engages the wider public. Sharing learning resources such as case studies and videos have been encouraged as a way of helping participants feel connected with the whole shared learning experience (http://eqrecoverylearning.org).

causes of events and the accountability of all involved. This is a necessary condition not only for individuals' journeys towards recovery but also for society's learning, implementation of lessons and mitigation of future risks. If not what basis can there be for hope that lessons really have been learned?

Participative approaches to learning reviews

Participating in learning reviews is a further example of the opportunities to make sense of the past and give hopeful meaning to the future following CTE. As illustrated in the 9/11 Commission above, formal acknowledgement of these principles translates into including those who have been directly affected by CTE in these and wider, important political processes.

An example of this is the London Assembly's review of the response to the July 7 attacks, 2005, which set out to consider the issues on that fateful day from the point of view of a member of the public. To this end the Committee heard testimony not only from responding organisations but also from those caught up in the attacks (2006:6). Furthermore their report was organised around the needs of individuals during each phase of the response rather than around the actions of the responding authorities, and presented in such a way as to reflect and effect a change in mindset: 'to bring about the necessary shift in focus,

from incidents to individuals, and from processes to people' (2006:9).

Calls for a change in approach to mitigate the pain and suffering of bereaved people and survivors through post-incident legal processes have been reinforced more recently in a report by Bishop Jones following his review of the experiences of bereaved families form the Hillsborough Disaster. Strongly influenced by the testimony of families around their treatment during both following the disaster and subsequent legal processes, the report calls for institutional changes in favour of putting bereaved families at the heart of post-disaster processes (Jones, 2017; BBC, Nov 1 2017).

Consequently, the direct participation of those caught in the 2017 Manchester Arena attack, including bereaved families and survivors, has also been actively sought in the Kerslake Arena Review which is examining responses on the night and during the following week and identifying what helped people and what could have been done better[8].

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8. https://www.kerslakearenareview.co.uk/

Continuing improvement in psychosocial responses

There have also been calls for the voice of service users to be more extensively drawn on in identifying learning from longer term psychosocial responses. Almeida and Moroz (2017), for example, recommend a review of the challenges experienced by service users following terrorist incidents to fully understand areas that require improvement. They suggest that evaluation of victim services and their ongoing partnership working is vital to ensure those affected by any future attacks get the support they need, when they need it (2017:11). Indeed, as others have said, within the disaster cycle effective learning is the fundamental basis for continuing improvement, better planning, training and preparedness, activities which lay 'the foundations of a quality victim-oriented response' (Ivankovic et al 2017:123).

With this in mind it is also significant that many writers over time have emphasised the importance of recording and disseminating lessons from each response in order to allow future plans and response to be refined and enhanced. Gibson (1994:133), for example, 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).

Having said this, an earlier review has noted the wide variety in the methods, type and depth of learning review and evaluations of responses to forms of post disaster support and it has been suggested that a more systematic and uniform approach to recording lessons and evaluating psychosocial provision would offer great benefit (Eyre, 2007). More broadly this finding reflects a further theme noted throughout this review, namely that varying definitions and conceptual interpretations result in differing operational practices. Recommendations around definitional clarity and standardisation apply not just to psychosocial support and psychosocial strategies, but are also relevant in considering other key concepts discussed in this review including community resilience, social capital and recovery.

7. http://govinfo.library.unt.edu/911/family/index.htm

SUMMARY

- Meaning making is an important aspect of coping and recovery following CTE

- Focussing on meaning making is compatible with promoting evidence-based psychosocial principles

- Making sense of CTE is achieved through having good communication, memorialisation and access to justice

- Opportunities to participate in ritual acts and memorials are important following collective trauma

- CTE can affect people's sense of meaning, justice, and order

- It is important to include those directly affected in legal, political processes, including learning reviews

CONCLUDING COMMENTS AND STATEMENTS TO TEST WITH SUBJECT MATTER EXPERTS

Clear themes have emerged across this literature review on collective trauma events and its analysis of the impact and implications to support communities such as:

- Coordination and capacity building
- Communication
- Planning. Support and service delivery
- Monitoring, Evaluation and Learning

For each theme, best practices have been identified before, during and after a collective trauma event. These practices will be tested in a survey with subject matter experts. They can be found in the table 2 below and in the report Best practice guidelines: *Supporting communities Before, During and After Collective Trauma Events*.

The full report can be found here redcross.org.au/ get-help/emergencies/resources-about-disasters/ help-for-agencies/CTE-best-practice-guide

Table 2: Summary of best practices before, during and after a Collective Trauma Event (CTE)

BEFORE	DURING	AFTER
Coordination and capacity building		
The emergency management sector and community groups, organisations, networks and businesses should engage with each other before a collective trauma event		Community groups, networks, organisations, businesses and GPs should be engaged in the aftermath of a collective trauma event and supported to understand their role in recovery
Organisations should be supported to develop business continuity plans that include collective trauma events		
Communication		
Advice should be provided to key leaders about conveying messages that are inclusive, relevant, clear and targeted—these messages will need to manage expectations in the aftermath of a collective trauma event	Relevant communication channels should be used to promote psychological first aid messages	Longer term information and advice should be available and sustained through an open, centralised communication channel
Organisations should be supported to develop communications plans for a collective trauma event that promote the principles of psychological first aid	Relevant communication channels should be used to promote social cohesion messages	Relevant communication channels should be used to remind people that collective trauma events may have long-term impacts
Plan for a central point of communication prior to a collective trauma event	Communication should take into account the diverse needs of communities	Relevant communication channels should be used to advise affected people about continuing support services
	Take steps to promote the responsible use of social media during a collective trauma event	
	Communication should take into account the needs of the broader community in addition to those directly affected	

8. https://www.kerslakearenareview.co.uk/

Planning and service delivery	Support and service delivery	
Community members should be trained in first aid in preparation for a collective trauma event	Key local stakeholders such as community groups, networks, organisations, businesses and primary health practitioners should be involved in coordinated efforts around service delivery	
Community members should be trained in psychological first aid in preparation for a collective trauma event	Activities and services that promote psychological first aid principles should be implemented during a collective trauma event	
Community members should be helped to prepare for a collective trauma event		
Plan for a range of services which may be needed after a collective trauma event	People affected by a collective trauma event should have access to a range of supports	Longer term support services should be available based on continuing or emerging needs
Plan for the people impacted by a collective trauma event to be geographically dispersed		
Plan for psychological first aid to be delivered in the hours after a collective trauma event	Psychological first aid should be implemented as part of the immediate response	
Plan for support for those who extend beyond the 'directly' affected		
Identify the diverse needs of the community	Services responding to a collective trauma event should take into account the diverse needs of the community, including those of children and young people	Support should be aimed at multiple levels, including individual, family and community
Identify groups that are likely to be targeted and harassed in the aftermath of a collective trauma event	Coordinated efforts should be made to monitor discrimination or harassment towards targeted groups during and after a collective trauma event	Discrimination or harassment affecting targeted populations should be addressed
Plan ahead for the needs of children and young people		
Identify how support services will link to investigation and coronial processes	Support services should link to investigation and coronial processes	Longer term support services should link with investigation and coronial processes
Plan for engaging those directly impacted in temporary memorial management		People directly affected should be consulted around memorial and commemoration events

7. http://govinfo.library.unt.edu/911/family/index.htm

Monitoring, evaluation & learning		
Feedback from previous collective trauma events should inform preparedness for future events		Reviews of support should include evaluating long-term recovery services
A set of key indicators to monitor the impacts of a collective trauma event should be developed and agreed on before a CTE	The impacts of collective trauma events should be monitored against a set of key indicators	The impacts of collective trauma events should be monitored against a set of key indicators
A set of key indicators to monitor and evaluate the response and recovery efforts should be developed and agreed on before a collective trauma event	Service provision in response to a collective trauma event should be monitored against a set of key indicators	Recovery services should be monitored against a set of key indicators
Information about work already done to help communities to prepare for a collective trauma event should be captured		People directly affected should be involved in evaluating the quality and efficacy of response or recovery support services

8. https://www.kerslakearenareview.co.uk/

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