

ABSTRACT

Despite great advances in emergency management, we live in a world where the incidence of individual and collective loss, bereavement and trauma and the need for post-disaster support is as great as ever. The provision of formal and informal psychosocial support is not new. However, some interesting models of post-disaster support have emerged following recent disasters such as earthquakes, tsunamis and deliberate acts of violence including terrorism. This paper highlights the implications for future psychosocial support provision as identified through a review of three post-disaster psychosocial support programs. Following a review of evidence-based principles, guidance on the organisation and delivery of support is contrasted with recent evidence. This suggests that bereaved people and survivors can fall through gaps in post-disaster support and struggle to access peer-support services. Those who have received support have provided feedback to benefit others. The aim of this review is to assist the sharing of lessons and implications identified by participants of an evaluation and review of three bespoke support programs.

Lessons in providing psychosocial support: a review of three post-disaster programs

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Introduction

The availability of social support has long been recognised as an important factor influencing levels of psychosocial health and welfare after disasters. As well as social embeddedness (the size, activeness and closeness of a survivor's network) received and perceived social support is critical for disaster victims. Norris (2008) states that:

With few exceptions, disaster survivors who subsequently believe that they are cared for by others and that help will be available if needed, fare better psychologically than disaster survivors who believe they are unloved and alone. (Norris 2008)

Principles of psychosocial support

The Australian Red Cross is among those organisations that recognise the significant ways in which people's lives change as a result of a disaster and what it means to adopt a psychosocial approach to preparedness and recovery activities. Drawing on empirically supported intervention principles aimed at intervention and prevention efforts after mass traumatic events (Hobfoll *et al.* 2007), John Richardson (2016) describes how organised support activities can reduce the psychosocial impacts of disasters. Promoting a sense of safety (by encouraging people to understand the risks they face and having an emergency plan to manage their safety), a sense of calm (through stress management strategies) and hope (through preparedness activities) are all fundamental.

Hobfoll and colleagues (2007) highlight two further key approaches focused specifically on enhancing resilience as fundamental to psychosocial support and recovery strategies. These are promoting connections and promoting a sense of self- and community-efficacy. A focus on self-efficacy does not mean that assistance such as mentalhealth and other services are not needed. Rather, such services should be delivered in a way that provides resources without threatening those resources. For example some people are more likely to accept help for 'problems in living' than to accept help for 'mentalhealth problems'. Norris (2008) states:

In exercising our good intentions to help victims, we must not inadvertently rob them of the very psychological resources they need to persevere over the long term. (Norris 2008)

The emphasis here is that it is not just a question of *what* support is provided but how it is given, *who* by and *how long* for.

Organising post-disaster psychosocial support

Psychosocial approaches should be proactive, pre-planned and integrated with other elements of a person's recovery. The organisational implication of this is that long-term psychosocial support should be intrinsic to any pre-incident planning and post-incident recovery arrangements (Department of Health 2009).

Good practice (NICE 2005) and government guidance documents reinforce this. For example, current UK government guidance states that addressing the human aspects of emergencies requires leadership and careful coordination as part of the response effort (Cabinet Office 2016, p. 11). It reinforces earlier strategic guidance stating that when a humanitarian assistance capability is fully embedded a community can expect to receive a coordinated, effective and sustainable response from public, private and third sector organisations in the UK over the immediate and longer term (DCMS 2011, p. 8).

Falling through the gaps

The evidence-based planning principles and moral arguments for providing appropriate psychological and social support after disasters are not contentious. It is often the case that immediate measures are taken to help affected groups and that, overall, such help has become more organised and structured than in the past (Dyregrov *et al.* 2009). It is also true that in the long-term people affected by major incidents find themselves feeling isolated, unsupported and falling through gaps in accessing psychosocial support (Reifels *et al.* 2013).

Research in the UK in 2016 with bereaved families and survivors of terrorism commented on the severe ripple effect of disasters and found that gaps in recovery support means those affected often struggle to access what they need to move beyond the incident (Barker & Dinisman 2016, p. 7). One reason is that in the absence of a widely recognised definition of a 'victim' of terrorism, 'witnesses' are not always considered to be victims. The result is that there is no guarantee that a British national or resident who has suffered psychological injuries or less serious physical injuries as a result of an act of terrorism overseas will be referred to victim services (Barker & Dinisman 2016, p. 8). Furthermore there is a lack of clarity as to where survivors should seek information about the support they can receive and the options available. In addition, for some survivors and bereaved family members, the waiting times to receive counselling or therapy services through the UK National Health Service can seem too long. Access to peer-support groups, particularly locally, can also be problematic.

Notwithstanding this, there are examples of good practice in psychosocial support provision that have been implemented in the aftermath of disasters. Three case studies are used to consider practice types. Although each was initiated in response to a different type of incident, in different countries, at different times and in the context of different emergency management frameworks, some common experiences and implications emerge. These examples illustrate the issues and challenges and offer lessons to consider for the future.

The British Red Cross Tsunami Support Network, 2004-2005

On 26 December 2004, the Indian Ocean tsunami killed an estimated 280,000 people across 14 countries with Indonesia being the worst-hit country, followed by Sri Lanka, India and Thailand. Approximately 10,000 British nationals were in areas affected by the tsunami and 151 British lives were lost (the exact number of injured is not known) (National Audit Office 2006, p. 3).

In the aftermath of the disaster the British Red Cross established a telephone support line and, with other specialist and voluntary organisations, deployed a psychosocial support team to Thailand. Red Cross representatives also met people returning home through UK airports. The Foreign and Commonwealth Office asked the British Red Cross to also assist in addressing the long-term needs of affected UK citizens. Consequently, in the UK, the British Red Cross established a family and peer-support network for bereaved families and survivors. This became the Tsunami Support Network (TSN) that ran for 18 months. The British Red Cross Support Network also managed the Tsunami Hardship Fund from November 2005.

The TSN provided a range of services during the 18 months including a dedicated website, telephone and email support, newsletters, information meetings and regional bereaved and survivor support groups. The aim was to provide individuals affected by the tsunami access to information, guidance and advice and opportunities to share experiences and benefit from peer support. In keeping with the principle of enhancing resilience and efficacy, a fundamental aim was to enable the network to become self-sustaining as soon as possible. A multi-agency steering group included an advisory role for Disaster Action.¹

The National Audit Office conducted a review of the experiences of British nationals affected by the tsunami. The Office found that the provision of aftercare generally (as experienced by respondents) was often variable and lacking. However, the TSN and other agencies provided supportive advocacy and were experienced and effective. The services and support provided by the TSN had the highest satisfaction ratings reported by the survey respondents. Based on the findings,

¹ Disaster Action is a charity where members have direct experience as bereaved people or survivors and who have experienced disasters and understand their consequences.

the National Audit Office report identified a number of recommendations for planning, preparation and long-term support including government departments having plans to establish comparable support networks (i.e. independent of government and accessible via a variety of means as quickly as possible following a major disaster). The report stated:

Regard should be given to the good practice seen in the establishment and development of the Tsunami Support Network, particularly the way in which survivors and families acquire(d) ownership of the Network over time. (NAO 2006, p. 15)

Norway's collective assistance following terror attacks in 2011

On 22 July 2011, a lone gunman killed 77 Norwegians in a series of terror attacks on government buildings in Oslo and then on a youth camp on the island of Utøya. This was the deadliest attack on a largely peaceful country since World War II. It represented a national tragedy that profoundly affected the entire society (Dyregrov *et al.* 2014, p. 1, Reifels *et al.* 2013). The killings on Utøya meant that about 210 parents and siblings lost a child or a sibling. In addition, some lost their partners or parents and many adolescents lost a close friend (Dyregrov *et al.* 2014).

A Scandinavian collective assistance approach to support the bereaved following disasters had already been established in Norway (Dyregrov *et al.* 2009). In 2011, the approach was implemented again when public health authorities instructed municipalities to offer outreach to those affected. They advised that helpers should initiate contact with the bereaved and offer everyone affected, including survivors, a designated contact person and follow-up contact points for at least a year. Frequent contact, for example weekly, was recommended during the initial period, with ongoing support adapted to individual needs. In addition, educational institutions offered outreach support to pupils and students. For those directly affected, four weekend gatherings were organised.



The granite monolith outside London's Natural History Museum commemorates victims of the 2004 Indian Ocean Tsunami. The design was developed through dialogue with UK survivors and bereaved families.

Image: Natural History Museum

The Center for Crisis Psychology (CCP) in Norway conducted research with parents and siblings 18 months after the attacks on Utøya and collated the views, experiences and advice for future public support systems (Dyregrov *et al.* 2014). The CCP found that bereaved people expressed greater need for help and had been given more comprehensive and proactive support services than others bereaved by previous violent events in Norway. It was suggested that the increased intervention was due to help being locally provided as well as increased general knowledge of the serious consequences that follow violent death. They also cited increased levels of psychosocial preparedness in the municipalities as a factor and a positive move away from earlier 'wait and see' or 'watchful waiting' practices to an acceptance of the value and importance of early outreach. Dyregrov and colleagues (2014) concluded that:

*...consensus has moved in the direction of professionals discussing only to a limited extent whether it is necessary to help after potentially traumatizing events, and to a greater extent discussing how that help should be, and what kind of help is needed. (Dyregrov *et al.* 2014)*

New Zealand Earthquake Support Program, 2011-2015

Earthquakes in Canterbury in 2011 resulted in 185 deaths. The New Zealand Red Cross (NZRC) provided support for those who were bereaved or seriously injured. The range of services and activities included cash grants, support groups, social activities (including children's activities), retreats and expert talks. The program was transitioned to the Quake Families Trust in 2015.

To evaluate the services and inform future programming the NZRC used semi-structured interviews with program participants and involved current and former NZRC staff and a NZRC Board member. While the study had its limitations (including self-selection and limited representation of seriously injured and overseas families), useful feedback was received (NZRC 2016, Wills 2017).

While the number of regular attendees at the monthly support groups was small, its value increased after time. Bereaved interviewees appreciated the NZRC encouraging people to be open to accepting support. They also appreciated the NZRC organising counselling venues for them and respecting privacy by withdrawing from facilitated sessions. It was suggested that opportunities for new and prospective members to meet socially prior to attending a bereavement group, for example by attending quiz nights or children's activities, was helpful.

Similar to the Norway experience, four retreat weekends were held allowing bereaved people to meet up and to socialise. Despite some initial anxiety about attending these occasions they proved beneficial to many. Helpful aspects included the wide range of activities offered, chances to participate in planning to ensure the right mix, variety and suitability of activities and supervision for children giving parents some time out. Attendees

also appreciated the freedom to not talk about their experiences and did not feel pressured to participate in activities.

A program for the seriously injured, which was jointly organised with Burwood Hospital, experienced a delayed start due to the lack of a clear mandate. Once up and running, participants appreciated the time taken to identify their needs and determine what sort of assistance would be most suitable. A series of talks given by Australian trauma psychologist, Dr Rob Gordon, was considered one of the most valuable components of the program. These sessions were open to family members and children, where appropriate. The talks were made available on DVD as an ongoing resource and this increased the outreach to those who might not seek support.

Using qualitative insights to review post-disaster support

Due to their very nature it is neither easy nor appropriate to produce large-scale, purely quantifiable and objective indicators for measuring the impact and value of psychosocial support services after disaster. Relying on numbers of individuals accessing services to measure effectiveness is inappropriate where the existence and symbolic offer of support has value and therapeutic effect (perceived support) even though it may not materialise into uptake of services. Similarly a sign of 'success' for services may mean uptake drops off precisely because users have been able, through initial help, to access their own self-efficacy and resilience and no longer need to rely on external services. In the case of the Norway program, continued help beyond the first year and a half was identified as important even though the scale of help showed a natural decrease, a pattern also found with the TSN.

In these three support programs, although the number of participants and survey respondents were small relative to the number of people affected by the disasters and the studies suffered from other limitations, they offer useful, qualitative insights into opportunities and limitations in post-disaster support. There is also intrinsic value in the fact that users were consulted, listened to and affirmed. By participating in the reviews they felt they were making a difference to those who might find themselves in similar positions in the future.

Lessons and implications for future psychosocial support programs

Effective communication and information-sharing

In these three cases, notwithstanding overall satisfaction, users made suggestions for future

support services based on their experiences. Finding out about available programs and activities was often a challenge for those affected particularly for people in geographically dispersed areas. For example, people outside Christchurch or overseas who were affected by the Christchurch earthquake had difficulty staying informed of the recovery process. Similar problems were faced by service providers in NZ and the UK in accessing details of those affected (and thereby knowing who could benefit from outreach) due to restrictive information-sharing protocols. In the UK similar challenges arose after the tsunami in 2004 and the 7 July 2005 bombings that led to the issuing of guidance on data protection and data sharing for emergency planners (Cabinet Office 2007). Having effective communication strategies for raising awareness of services and appropriate protocols around information-sharing, privacy and confidentiality remain important considerations (Disaster Action 2017).

Expertise, understanding and 'chemistry' with helpers

In all three programs the involvement of specialist health practitioners, including access to experts in disaster grief and trauma, made a difference to participants. The TSN included helping individuals access specialist psychological counselling where needed as well as linking to online discussion forums organised by a charity offering specialist grief support for bereaved children. In all three programs specific help and support targeted at children and young people was identified as an important factor that made a real difference.

In the Norway experience bereaved people highlighted the importance of understanding, empathy and 'chemistry' with their helpers. Dyregrov and colleagues (2014) assert that ensuring the chemistry between the two parties is 'right' is also decisive when applying good, professional competence in meeting with the bereaved. In New Zealand, Dr Rob Gordon was identified as the type of professional with the special qualifications and ability to explain post-disaster grief and stress in a way that participants found familiar and helpful. As one interviewee said 'he doesn't use psychobabble, he just talks like an ordinary person' (NZRC 2016).

Promoting efficacy and facilitating ownership

An important lesson was the need for support services and program coordinators to balance providing specialist help and support with an approach that enabled people to feel validated and be 'experts' in their own experience and providers of mutual support. Facilitating supported sharing, knowing when to leave a meeting and allowing people to take ownership of their recovery as well as the evolution of a program or support group all promote self and community efficacy.

The National Audit Office report outlined learning points from the TSN as:

...the way the Network moved quickly away from methods based on "experts talking at" those affected, towards approaches that allowed people real participation and ownership in the Network's activities. (NAO 2006, p. 14)

Similarly, in New Zealand, feedback from the bereaved suggested they greatly appreciated being able to provide direct feedback throughout the program and felt in control of its direction. In Norway, researchers concluded that the bereaved need to be listened to so that advice can be adapted to the situation of the individual and the family. As a result users are taken seriously, and their empowerment and autonomy are strengthened (Dyregrov *et al.* 2014).

Conclusion

The conclusions and implications from Norway are echoed by the other programs reviewed here. The similar and repeated feedback from those bereaved by traumatic death highlights the importance of our listening to them. Other key messages from this cross-program review are that user satisfaction among survivors and the bereaved is increased when help is proactive, well communicated and coordinated, is provided by helpers with the right knowledge, competence and understanding, reinforces evidence-based principles for enhancing psychosocial resilience and efficacy and continues over a longer period of time.

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