POLICY REVIEW

Meeting the needs of people in emergencies: a review of UK experiences and capability

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This article summarises the key findings of two research studies conducted for the UK Government in 2006–2007. The first was a literature review of evidence about provisions and interventions to meet the needs of people affected by ‘emergencies’ as defined within the Civil Contingencies Act (2004). Drawing on both historical and contemporary research and practice, the literature review presented an assessment of people’s psychosocial needs after events such as natural disasters, terrorism, and other major incidents. Although some reference was made about the needs of and consequences on disaster workers responding to these events, the main emphasis was on those directly affected as bereaved people and/or injured survivors. The review offered best practice guidelines based on the most effective methods of humanitarian assistance in the immediate, short-term, and long-term aftermath of major emergencies. The second report was a follow-up study conducted in 2007. This was a piece of primary research focusing on the UK’s current capability in humanitarian assistance in terms of the extent of planning, training, exercising, and experience relating to meeting people’s needs in emergencies. A variety of methods were used to gather quantitative and qualitative evidence of the nature and status of such activity across the UK, including questionnaires, focus groups, and a review of literature and documentary evidence. The report included a number of good practice case studies and made recommendations for the development of best practice in humanitarian assistance within the UK.

Introduction: defining emergencies and humanitarian assistance

The nature and types of emergency included in both works reviewed here are based on the definition of ‘emergency’ as per the Civil Contingencies Act (CCA) 2004. Developed against the backdrop of the experience of the fuel crisis, the outbreak of foot and mouth disease, floods, fires, and the terrorist attacks of 11 September 2001, ‘emergency’ is defined within the Act as

‘An event or situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK’.

The terms ‘emergency’ and ‘disaster’ are used interchangeably throughout this review. Whatever terminology is used and whatever be the types of event, it is important to remember that all such incidents are not only physical events requiring procedural approaches to planning and response but also psychological and social events. These dimensions of their cause and impact are considered specifically in this review.

Humanitarian assistance here refers to ‘those activities aimed at meeting the needs of people affected by emergencies. In particular, this includes those elements of planning, training, and exercising that are aimed at meeting people’s practical and emotional needs; response activities focusing on meeting people’s needs during and immediately after emergencies; and the coordination and provision of psychological and social aftercare for those affected in the weeks, months, and years that follow.’³

It was important to include such a definition in the primary research study (2007) because the sorts of activities covered in this diverse and multi-agency field of work have been variously referred to over time and place. In the UK, this includes concepts such as humanitarian assistance, care of people, human aspects, community support, crisis support, family assistance, disaster aftercare, victim support, psychosocial services, emotional first aid, spiritual care, welfare provision, trauma support, social care, and disaster counselling.

Methodologies used

Both domestic and international empirical evidence was drawn on for the literature review. This spanned a range of disciplinary sources, including psychological, sociological, and social work-based approaches. The emphasis was more on common findings of psychosocial issues across disasters rather than an analysis of specific incidents or events, although some illustrative examples of models of intervention following particular events were included. Academic articles, accounts, and reports by those providing and using the services were also referred to. A discussion about the quality of programme evaluations and the appropriateness of generalising lessons and recommendations from particular events and differing sources was included in the analysis.

The methods of data collection used in the primary research included a survey consisting of two questionnaires to be completed: one for local authorities and the other for Local Resilience Forum (LRF) representatives in England and Wales. In addition, a series of focus group discussions were conducted at regional workshops as well as targeted interviews with key individuals. These focused on issues such as the development and distribution of the survey, particular approaches and experiences of planning and response, follow-up queries relating to the documents submitted through the survey, and permission for the inclusion of good practice examples in the final report.

Disaster impacts: ripple effects

The literature review highlighted that because of their nature and scale, when disasters occur, large numbers of people are likely to be affected, both directly and indirectly. Taylor and Fraser's⁴ classic typology of disaster victims used the imagery of a ripple effect of events based on factors such as proximity to the impact zone and psychological consequences of the disaster experience. Under this classification, potential victims include not only those directly injured (physically and psychologically) and those bereaved, but others who may be involved either as witnesses or responders, both in the short or longer term. This work highlights that the line between victims and non-victims is not as obvious as it might appear at first; beyond those who have been hurt physically, or incurred losses of possessions, are a wide variety of 'hidden victims'.

Marshall *et al.*⁵ reinforce the importance of going well beyond just the ripple effect or traditional 'bull's-eye model' in addressing the psychological effects of events. They highlight the findings of research after the September 11 attacks, which suggested that indirect exposure to the 9/11 attacks was responsible for causing clinically significant levels of post-traumatic stress disorder (PTSD) symptoms in the general US population, with an unknown long-term impact on mental health and functioning, public health, the economy, and the society. The authors suggest that the presence of persistent fears in the general population of being personally harmed in future terrorist attacks is a poorly understood phenomenon that may represent vulnerability in the general population. This suggests that we need to go

beyond the simplistic bull's-eye approach in understanding the potential or actual psychosocial impacts of emergencies on populations. Another research complements this approach, particularly in relation to addressing the particular implications of large-scale terrorist attacks for individual and community mental health interventions.⁶

The UK's experience of extensive floods in the summer of 2007 illustrated this more complex picture of risk and vulnerability within disaster-affected communities and the significance of fear as a risk factor. As one report stated, 'Feedback at the inquiry's public drop-in sessions indicated that there may be some longer-term impact on some residents. Members of the Inquiry team heard stories of residents being fearful every time it rains in case they flood again, and of children being scared of the rain and hiding away at the first sign of rain. In one instance, an elderly resident commented that he would rather die than go through the same experience again'.⁷

Previous research had highlighted that the mental health effects of flooding can be serious and long lasting due to the stresses of the event, difficulties coping with the recovery process, financial concerns, and anxiety over future events. The experiences of 2007 reinforced the findings of earlier studies that anxiety whenever it rains leads to increases in stress and problems in sleeping: 'one strong message that came through is that people are now feeling very vulnerable and dread the approach of winter'.⁸

This highlights other research findings showing that susceptibility to post-trauma reactions is influenced by a range of other factors as well as the disaster experience itself.⁹ For these reasons, it is not helpful to simply equate the nature of disaster reactions with degree of proximity to the event, and those wishing to understand and plan for psychosocial responses should be wary of applying definitions and concepts of disasters and victims superficially and uncritically.

Individual and collective trauma in disaster

Erikson^{10,11} reinforces the importance of understanding the grassroots social and collective experiences of disaster impacts. Based on his observation and analysis of a number of disaster-struck communities, he describes how those involved share an enormous experience and come to view the world around them in new and different ways. His writing makes much of the communal effects of disasters. Today, our concepts of the nature of 'communities' affected by an incident might be even more extensive than ever and as much virtual as physical given the ever-increasing power and reach of technologies, such as the Internet and satellite television.

Erikson¹² writes of two types of disaster trauma: individual trauma (a blow to the psyche that breaks through one's defences so suddenly and with such brutal force that one cannot react to it effectively) and collective trauma (a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality). His and other long-term disaster

studies highlight how planning and interventions should consider the effect on and outreach to communities at large about both the personal and collective effects of disaster. This includes addressing the range of social and psychological consequences of disasters, from grief, loss, and normal post-traumatic stress reactions, through to PTSD and post-traumatic growth.

Research after disasters has also shown that the psychological and social effects of emergencies are many and varied. Apart from grief, trauma, stress, and other forms of loss-related reactions, the evidence suggests that people are generally resilient and demonstrate the ability to adapt, adjust, and recover after such events. Experience has indicated that there is often a strong willingness and desire among affected individuals and social groups to engage in active, community-based activities in the aftermath of an event. The ability to cope is related to a range of pre-disaster, within-disaster, and post-disaster risk factors. The implications of such research are that providing information and facilitating activities that normalise reactions, protect social resources, and signpost further sources of support are fundamental to a good psychosocial response.¹³

Origins of formal psychosocial disaster response in the UK

The recent historical development in the UK of formal humanitarian assistance or organised psychosocial support after disaster can be traced back to the tragedy at Aberfan in 1966, where 144 people died after a coal tip slid down a hillside onto the village school and surrounding streets in a small, close-knit mining community in South Wales. The disaster occurred at a time when there were few trained responders available, and no agreed or proven methods for supporting people affected by disasters were known.¹⁴ Hence, local doctors and social workers in the aftermath of that disaster acknowledged that the community would need professional psychological and social work support. One of the biggest challenges at that time was the acceptability within the community of such help, given that there was much less understanding then of trauma and bereavement, and a reluctance to seek help for fear of being stigmatised.¹⁵

Initial practical help (such as assistance with filling in compensation forms) was provided by an advice centre that was quickly set up and staffed by the local Council. The local authority decided to reject outside offers of counselling and psychological support in favour of local services, although this was limited to two psychiatrists and three local general practitioners (GPs). Plans to seek outside help to assist these limited resources seemed to founder owing to a lack of trust.¹⁶ In addition to this, administrative divisions between the education and health departments of the local authority hindered communication between those treating adults and children. Initially, nonpsychiatric help was limited by resources: two mental health officers and five social welfare officers who were not sufficiently trained for the job.¹⁷

Eventually, a family caseworker was funded by the local authority and played an invaluable role: visiting families, providing listening support, and encouraging the formation of bereaved support groups. After two years, although she felt the work was unfinished, the funding ended and so no further daily help was available.

Significantly, community self-help networks developed in Aberfan alongside professional help and became integral to people's recovery. This included a community association facilitated by the local council of churches. Earlier, we discussed the importance of protective social resources and political factors affecting post-disaster recovery. At Aberfan, obstacles to recovery included the arguments relating to the disaster fund (which became known as the 'second disaster'), political wrangling (including the government's two-year delay in removing the remaining tips), and cultural attitudes. In particular, traditional male working-class notions of masculinity meant that male grief was denied rather than shared and faced.¹⁸

Later studies have given some insight into the long-term effects of this disaster within the community. Local GPs' records and psychiatric reports suggested significant levels of health problems. Resilience was also evidenced, however, with social workers at the time reporting that villagers grew out of adversity and benefited from the unity brought about by the disaster.¹⁹ A study of survivors by Morgan *et al.*²⁰ more than 35 years later found that almost one in three children who lived through disaster continued to suffer from problems such as nightmares and difficulty in sleeping. The study found that the intensity of the experience of disaster, a characteristic symptom of PTSD, was still very much present in some of the survivors' lives. The researchers concluded that children can be affected by traumatic events in a similar way as adults and are not necessarily more adaptable or malleable than adults.

As with other cases of PTSD, research after this disaster found that those with adverse reactions who did not receive help and support were vulnerable to reactions much later on. Wells²¹ cites the example of a woman who witnessed the disaster as an 11-year-old child and went on to sue British Coal for damages, claiming that the horrific scenes caused her to suffer a nervous breakdown 12 years later. She said that she blanked out the memory of the day until she read newspaper reports about a man and his children who died in a fire. The case only went to court in 1995.

The development of psychosocial support

Organisational responses to Aberfan reflected levels of knowledge and understanding of the time. As the years progressed, many lessons were learned about psychosocial support after a series of man-made disasters during the late 1980s. A series of human-caused events resulting in several mass fatality disasters (including the terrorist attack on a plane over Lockerbie; transport disasters at Clapham, Zeebrugge, and Kegworth; and the soccer tragedies at Bradford and Hillsborough) led to the development and

formalisation of emergency procedures across the emergency and other services within the UK.

According to Hodgkinson and Stewart,²² these events emphasised the total lack of preparedness of the health services, social services, and voluntary organisations for mounting long-term psychosocial support. 'No social services department involved in any of these catastrophes had a plan that detailed the possible mechanisms for a psychosocial response to survivors, despite the fact that such departments are run by local authorities, which have a responsibility for emergency planning.'²³ They further reported that there was no coordination between health authorities and local authority social services departments despite being the two main statutory providers of care.²⁴

At this point, there was still only preliminary understanding of the nature of the psychosocial effects of disasters, including post-traumatic stress reactions and the need to plan for a coordinated approach to emergency planning and response. Nonetheless, crisis support teams did respond instinctively and went on to share a common understanding of the need for more guidance and preparation on how to meet the needs of those affected by future disasters.

Common features of responses at this time included the setting up of crisis response teams, help lines, information leaflets, and counselling services. The need for proactive outreach and better planning, training, accreditation, and support for the specialist role of crisis response workers started to increase.²⁵ In the following decade, expectations of these forms of response increased such that today they would be expected to be part of post-incident provision.

High expectations: a rights-based approach

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

Recently, psychosocial responses to the UK disasters have started to reflect this developing approach. In addition, the media reflect and influence public expectations about the level and standards of support that should be forthcoming after collective tragedy. On the first anniversary of the 2004 tsunami, the BBC reported that the Foreign Secretary Jack Straw had apologised to British families caught up in the disaster who did not receive adequate support, adding that although Foreign Office officials had done a 'fantastic job', it was not enough in some cases.²⁶ He referred to British citizens these days as having 'very high expectations of what the British government can deliver—and fair enough'.

With specific reference to psychosocial support, UK National Institute for Health and Clinical Excellence (NICE) guidelines on the treatment of PTSD have outlined the nature of information, care, support, and treatment that sufferers of PTSD can expect to receive from their GP and specialist mental health services.²⁷ International research and clinical recommendations reinforce this approach, which focuses on GPs offering 'psychological first aid', monitoring patients' mental state, providing general emotional support and information, and encouraging the active use of social support networks and self-care strategies.²⁸ Legislation, such as the CCA 2004, also sets the planning and provision of this and other psychosocial support within a statutory framework. Government guidance²⁹ recommends that local authorities and LRFs actively engage in multi-agency planning to address the needs of people affected by emergencies and support them through developing humanitarian assistance subgroups for effective planning, training, and exercising. In a positive sense, the UK has come a long way from the days after Aberfan, when the work of local welfare services after the disaster was deliberately not publicised for fear of making the situation worse.³⁰

Humanitarian assistance planning in the UK

Following up the literature review, the second study focused on the following aspects of preparedness for meeting the needs of people in emergencies: structures and arrangements for addressing humanitarian assistance across the UK; current plans in place for meeting the needs of those affected by emergencies; arrangements for humanitarian response teams, including their recruitment, organisation, and management; the training and development of personnel involved in humanitarian response; exercises and experience of humanitarian response and lessons learned; and procedures in place for meeting long-term humanitarian needs after emergencies. Through the survey and focus groups, emergency planning practitioners were also asked to identify challenges and opportunities they face in developing capability in humanitarian assistance.

The results of the study showed that there is a mixed picture of preparedness across the UK, with varying levels of interest, commitment, and activity within and across those tasked with such duties under the CCA and other responders. About 57.1% of LRF respondents reported having a lead responder in place for humanitarian assistance, and most of the local authority respondents (61.6%) had arrangements in place for welfare response (that is, for addressing psychological and social support), either through their own written plan or through mutual aid/memoranda of understanding. Responsibility for coordinating welfare response varied across, for example, social care and emergency planning. Arrangements for long-term psychosocial support were less clear, with some uncertainty expressed over who might have lead responsibility after emergencies. Although there were examples of good planning, training, and exercising in

place, commonly identified challenges included difficulty in engaging partners, confusion over roles and responsibilities, and structural changes in the public sector (for example, in social care), all of which led to confusion and uncertainty in humanitarian assistance planning.

Frameworks and structures for addressing humanitarian assistance

The research also demonstrated a general feeling that the national framework of government is useful, and the compartmentalisation of humanitarian assistance in the development of capabilities programme was generally seen as helpful. However, more clarity between tiers of local government and more joined-up government across departments would be helpful, especially in relation to the crossover between humanitarian assistance and other work-stream activities. While regional resilience teams were seen as bringing useful pressure and influence to bear in relation to humanitarian issues, with the authority for driving finances, raising profiles, and dealing with the media, there were calls for better sharing of knowledge and good practice, and buy-in from political leaders. The report highlighted the perception among grassroots planners that chief executives play a crucial role in providing direction, ownership, and drive for emergency planning activities, but this was felt to be currently lacking in many places.

Of 35 LRF respondents, 27 (77.1%) reported having a humanitarian subgroup in place in their LRF, whereas 8 (22.9%) said they did not. The statutory duty to undertake emergency planning had been helpful in enabling the establishment of subgroups and other strategic working groups with clearly defined terms of reference, leading to the production of plans and exercises. However, there were varying views on how LRFs are working. Where they were structured and working well, LRFs were regarded as offering helpful opportunities for both flexibility and standardisation in humanitarian assistance planning. But levels of preparedness varied widely; some were perceived as not operating in accordance with the CCA, and there were issues raised about accountability, leadership, engagement, and conflict.

Some (36.3%) local authority respondents had established formal humanitarian response teams for responding to emergencies, whereas others reported that they were exploring or reviewing these arrangements. There was a huge variation in the organisation, experience, training, and length of establishment of these teams. They ranged, at one end of the spectrum, from relatively recently formed groups relying on *ad hoc* arrangements to more established entities with some form of 'accreditation'. There was much reliance on volunteers here and calls for more guidance, consistency, and standards relating to this work.

The research also highlighted the need for more effective planning and greater awareness and availability of facilities for treating PTSD. When asked whether there were any specialist services included in their plans for treating people

with PTSD after an emergency, only 14 respondents (15.4%) answered positively.

Developing humanitarian assistance: challenges and opportunities

When asked to identify challenges in addressing humanitarian needs in emergencies, the issues identified included the following: lack of resources, multi-agency working, complexity of issues involved, infrequency of events, low priorities, managing expectations, and sharing of information and communication. It was suggested that the following opportunities might assist planners in addressing humanitarian needs in emergencies: increased funding/resources, clearer expectations and guidance, awareness raising, education, sharing best practice, and clarification of responsibilities.

Conclusion

This review has focused on the psychological and social impacts of emergencies and the development of humanitarian assistance activities aimed at meeting the needs of people involved in UK emergencies. Historical research has shown how the forms of humanitarian assistance have varied considerably over time, place, and incident, reflecting, in part, a developing understanding of the psychosocial impacts of disasters and lessons learned about the best ways of addressing people's needs.

Research carried out in 2007 highlighted a mixed picture of preparedness across the UK, with varying levels of interest, commitment, and humanitarian assistance activity within and across local authority and other responders. The report shows there is much good practice and much potential for further development, particularly in addressing long-term needs and recovery strategies as well as short-term effects and interventions. Beyond the general principles of good emergency planning and response captured in these reports and current guidance documents, definitive ideas of best practice in this field based on tried and tested solutions have yet to emerge. This is an area requiring continuous improvement through ongoing reflection, experience, and, crucially, the development of procedures for effective independent evaluation and review.

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