Community Support after Disasters

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Introduction

'Mind-blowing'… 'searing emotional pain'… 'aftershock'. These are some of the ways in which the attacks on the World Trade Centre on New York on September 11 2001 and their immediate aftermath have been described.

So how have the City and surrounding areas responded and recovered from such a catastrophic event in the longer term and what can we learn in the UK for our own emergency planning and response? These were among the questions that lay at the heart of my Fellowship Travels to New York and New Jersey in June/July 2006. Almost five years after the event my aim was to explore what lessons had been learned and how people were recovering in the longer term (see Appendix 1 for a summary of my mission and goals).

The heightened awareness and alertness relating to ongoing terrorism around the world today makes this work all the more necessary and relevant at this time. During the month of my visit alone we witnessed the first anniversary of the July 7 bombings in London, the latest coordinated terrorist attacks in Mumbai, India, details of a terrorist plot to attack tunnels connecting New Jersey and New York, and the introduction in the UK of a new warning system to alert the public to the threat of terror attacks.

These and other issues were discussed with those I met during my travels (a full list of people I visited is provided in Appendix 2). They included representatives from New York's police and fire departments as well as officers from the City and State's emergency management and mental health departments. Amongst others, I also met with members of the British Consulate, American Red Cross, New York's Disaster Interfaith Services and university researchers who have been examining the mental health impacts of 9/11 from that day onwards. I also had the opportunity to meet with those who have been involved in federally funded projects to respond to the mental health effects of disasters in both New York and New Jersey. My travels also took me to Philadelphia to meet with a researcher who is developing a pioneering model of community support after disasters.

A Personal Journey: Acknowledgments

The experiential 'journey' I have travelled over the last few months has been a deeply personal voyage as well as a professional one. This is due in part to the emotionally powerful nature of the subject which it is my vocation to study as well as the people who have facilitated each opportunity for me along the way. It started with the very positive and amicable welcome I received at the Churchill Trust's Office when I first travelled to London for my selection interview in January and continued from there. In the weeks and months that followed, every contact I made with the Trust was responded to warmly and promptly, making me feel as if I was the only person in the world, rather than one of many fellows for that year.

The correspondence and cooperation I have received from those in the US has also echoed this approach. A Reader's Digest poll recently voted New York City as the most courteous in the world (Destafano 2006). The hearty welcome and overwhelming support offered me by those in New York and surrounding areas both during the planning phases and during my fellowship travels certainly bears this out.

I would especially like to thank the following who have helped me throughout this project:-

- Mary Campion and Pamela Dix of Disaster Action and Duncan McGarry, Centrex's National Adviser for Police Family Liaison, who first recommended and supported my fellowship application.

- Mike Labate, Office of Mental Health, New York State who started the ball rolling with contacts and follow-ups in New York over a number of months and Leslie Slocum of the British Consulate who gave so generously of her time and contacts before and during my visit in putting together a packed and productive schedule for me.

- Barbara Maurer and Diane Travers, mental health consultants in New Jersey and colleagues on the Board of Directors of the Association of Traumatic Stress Specialists, who also provided me with superb support, contacts and practical advice over many months.

I would also like to thank all those who so willingly gave their time and hospitality in sharing their personal and professional experiences of 9/11 and after with me so openly. I felt we all shared in common a wish to extrapolate positive lessons for the future from the most challenging of circumstances that have arisen from recent disasters and their aftermath. For me the journey has been about looking back in order to move forward. I feel I have been able to share experiences and lessons from our own examples of collective tragedy in the UK and that opportunities for continuing collaboration and future exchange have been consolidated.

A retired fire-fighter who, like most people I met, had both personal and professional links to the disaster on 9/11, showed me around what remains of Ground Zero and took me to see the new fire-fighters' memorial there. It was particularly poignant to learn about that day and its aftermath by those with direct personal experience and on that occasion to be shown the site by someone who had been in the towers many times as a professional fire-fighter. No one I met during my meetings was unaffected by this work, though all demonstrated remarkable resilience in the face of adversity. This emerges as a key theme in the recovery of those involved in disasters.

Understanding the Context of Disaster

One of the aims of my fellowship was to explore comparative experiences of community impacts of disasters. I was aware before travelling to New York that when we talk about 'disaster', in the US it tends to refer generally to large scale, natural hazards such as hurricanes and tornadoes, while in the UK our events tend to be smaller-scale and humanly caused, such as transport or industrial accidents. Indeed during my visit I was able to witness first hand the extensive impact of a natural disaster as parts of New York State were declared a disaster zone following extensive floods which killed nine people across the region and lead to the evacuation of over 70,000 people in New York State alone. The Emergency Operations Centre was actively responding the day I had planned to visit it in Albany, the state capital, and through Mike Labate, Director of Emergency Preparedness and Disaster Response for the State's Office of Mental Health, I was given the privileged opportunity to visit the centre and observe the state's emergency response in action.

The events of terrorism currently being discussed in the UK and during my travels demonstrate a type of hazard and disaster that is increasingly being experienced across the world. These acts of deliberate violence make them scenes of crime and can have differing emotional and social consequences for those directly and indirectly affected. We all share similar challenges today and the nature and scale of terrorist events set new demands for all.

My discussions have reinforced for me the significance of political and cultural contexts in influencing the effects of disaster within communities and the way they are managed at different points in the disaster cycle. While there are similarities in the way in which we in the UK and US

conceptualise the phases of sudden onset disasters (i.e. before, during and after phases which correspond with mitigative, planning/preparedness, response, and recovery strategies), the role and function of mental health responses in these various phases has been differently perceived and implemented. I discussed with colleagues the way in which 'disaster mental health' as a specialism has evolved and grown in acceptance within the field of emergency management in the US over the last twenty years or so such that mental health elements are now integrated and included in most disaster plans, drills and response.

In the UK both the terminology and approaches are different. While the psycho-social elements of disaster are acknowledged, and recent legislation is influencing the extent to which disaster planning is incorporating ways of addressing psychological and social needs, notions of 'disaster mental health' and interventions tend to be differently applied. Historically in the UK, for example, we have been less likely to adopt and apply 'critical incident debriefing' models of response as much as in the US where paraprofessionals such as first responders have become involved in organised stress management interventions. While there are some examples of this and other outreach strategies in the UK, on the whole, we have tended to adopt more of a 'watchful waiting' approach after incidents, expecting that those relatively few people needing access longer term to mental health interventions and treatment after disasters will make recourse to specialist services.

There are pros and cons with both of these approaches, but interestingly both of our cultures today recognise the need for an outreach approach whereby a range of interventions and options are offered in the aftermath of events. The nature and effectiveness of such services and strategies was discussed in my various meetings and ranged from proactive outreach and awareness-raising to community based support interventions, specialist support groups and longer term psychological treatment.

Our discussions also highlighted ways in which political factors can determine the extent to which disaster support strategies are adopted and implemented. The difference between responses and resources deployed after September 11 and Hurricane Katrina came up a number of times in our discussions. I was able to talk about the London Bombings and the significance of the political environment surrounding the 7 July attacks and its aftermath for the organisation and resourcing of support services in London.

It was interesting to me to find that Israel's response to terrorist events was frequently referred to by my American colleagues. Much advice has been made available by Israeli consultants after 9/11 and this has proved most helpful given their historical experience of ongoing terrorism. In particular we discussed the contrasting approach to disaster sites which reflects both the political and social meaning attached to events and their location. In Israel, the site of a bombing is deliberately cleaned up and 'normalised' within hours; at locations such as Ground Zero and other commemorative sites in the US and UK, such sites become memorialised and the focus for political and cultural debates about the nature and significance of continued remembrance and commemoration.

My discussions reinforced the importance placed in our Western cultures of symbolically marking sites and giving families affected by events choices and control in relation to personal and public ritual and remembrance. We also discussed how commemoration can have negative effects for individuals, for example schoolchildren who lost parents at the World Trade Centre may feel singled out for attention every year when classroom silences are observed and banners everywhere remark on the need to 'Never Forget 9/11'.

In downtown Manhattan, one way in which the 5th anniversary of 9/11 will be marked is through a major conference hosted by Pace University's Centre for Downtown New York. The Centre was founded to serve the community as an academic, research and civic leadership partner in the effort to revitalize lower Manhattan in the aftermath of 9/11. The conference plans to focus on the

aftershock of the attacks but also on lessons learned and what lies ahead in terms of rethinking future planning and preparedness. This event and the Centre serve as examples of the resilience of the community and the opportunities for positive growth that are being adopted as part of the city's recovery.

Discussing the fifth anniversary of 9/11 and the controversies that continue in relation to the long term plans for the site, I was struck by the contrast between this and Israel's approach, both of which testify in different ways to the cultural meaning attached to the marking of events. Being in New York on the first anniversary of July 7 and away from home was also a poignant point of reflection for me.

The Effects of September 11

'You could have known 100 people who died that day; some people don't even know 100 people…' This comment made by one of New York's fire-fighters and peer counsellors during one of my meetings illustrates the very extensive impact of the events on September 11 on those in New York and New Jersey. The ripple effects extend well beyond the immediate geographical area of the financial district of Manhattan. One quarter of all the victims lost in the World Trade Centre were residents of New Jersey. Thus 'September 11 is a New Jersey story as much as a New York, Washington, or Pennsylvania story. For the families of the 691 residents killed on 9/11, there is no distinction, no state line' (Crimando & Padro 2005:107).

As well as the extensive loss of life and traumatic impacts on survivors, the economic costs were huge. The collapse of the towers and the damage to property in the Wall Street area removed almost 13m sq ft [1.2m sq metres] of office space from downtown Manhattan. As well as the cost of the clean-up and rebuilding work, New York has lost nearly $3bn in taxes as companies moved out of Manhattan into temporary accommodation in New Jersey (Wray 2002). In personal terms very many people were rendered unemployed or homeless by the disaster; these extensive long term economic impacts and ripple effects were often not acknowledged or understood by those outside the more immediate impact zones. In 2002 a report for Congress commented on the ripple effect of 9/11 on other sectors such as the airline industry and expressed doubt 'that the industry will survive in its present state' (Makinen 2002:54).

Five years on there has been much debate about the physical effects of the disaster on those involved in the longer term rescue and recovery operation at ground Zero. In 2005 the Governor signed a law granting Ground Zero rescuers a presumptive line-of-duty disability if they come down with certain illnesses. The law permits fire-fighters, police officers and other public employees who were involved in the World Trade Centre rescue, recovery or cleanup operations immediately following the September 11th attacks to more easily qualify for disability pensions on the basis of their being diagnosed with qualifying conditions or health illnesses. Diseases covered by the legislation include cancer, respiratory illness, psychological illnesses such as Post Traumatic Stress Disorder (PTSD) and certain skin conditions. The law also covers new onset diseases resulting from exposure which occur in the future such as cancer, chronic obstructive pulmonary disease, asbestos-related disease, heavy metal poisoning, musculoskeletal disease and chronic psychological disease. Officials are now expecting to see a dramatic rise in claims since those who qualify for the benefit are entitled to a 75 percent disability pension. I discussed with colleagues how this is likely not only to have a huge impact on coffers, but raises important questions about the appropriateness of legislation covering illnesses where scientific evidence about their specific cause is unavailable.

In terms of the effects of the disaster response operation on members of the emergency services, Dr Knour, Director of the Psychological Evaluation Unit at New York's Police Department (NYPD),

discussed with me the Kingsborough Project he helped to initiate with those police officers deployed to the rescue and recovery effort and the morgue in the months following 9/11. Recognising that prolonged and intense exposure might have long term after-effects, more than 1000 officers were offered the opportunity for physical and psychological health checks after the Ground Zero recovery operation closed in June 2002. Like so many of the support strategies I heard about, the procedures involved here were innovative, necessitated by the unique nature and context of the work these officers were undertaking. Knour was impressed by how hardy and resilient the officers were shown to be; he commented on their 'esprit de corps' and how the exaggerated reports of PTSD can often distort the real picture. 'I think resilience is under-rated' he said, and we went on to discuss the growing literature and evidence of resilience and post-traumatic growth in studies of disaster responders. Our discussion highlighted that support for those who undertook the recovery work, who were designated as 'heroes', was clearly one of the factors which enhanced the coping skills of those undertaking this task.

Beyond the physical and economic effects, 9/11 clearly impacted on the psyche of the nation as well as global community, shifting perceptions of personal safety and collective vulnerability. 'In an important sense 9/11 does mark the end of an era, for it reveals that the United States is vulnerable to attacks on its home soil' (Makinen 2002:54). Similar sentiments were expressed to me many times during my conversations and reminiscing on Churchill's famous speeches I wonder what he would have made of all this today.

Personal Testimony and Interventions

I feel privileged to have been able to hear first hand personal accounts of what happened in the first few minutes, hours and days on 9/11. These were shared by those who had seen the collapse of the twin towers with their own eyes and became part of the response and recovery effort over the weeks, months and years that followed.

Much of disaster mental health focuses disproportionately on extreme negative reactions following such direct experiences, but these accounts highlighted for me how resilient people can be in the immediate crisis phase of disasters and after. Those I met described the many tasks they and their colleagues undertook, often spontaneously and with little explicit professional planning and training, for example, triaging medical and psychological emergencies, evacuating victims from the immediate vicinity of Ground Zero, staffing helplines, coordinating family assistance centres, and distributing food and other supplies to the uniformed service workers who were searching for survivors from the first few days onwards. Their reflections and details of the scale and logistics associated with responding to the disaster highlighted the unique scale and impact of these events.

Having witnessed the collapse of the twin towers from his office window a few blocks away, Dr Richard Shadick, Director of Pace University Counselling Centre told me what happened. In his writing he has commented: 'While I had been trained to respond to crises with a full armamentarium of disaster management techniques, nothing could have prepared me for what was to follow. Over the next thirty hours, and for many months to come, I was required to perform a number of duties I never would have imagined doing' (Raskin et al 2002:35).

Dr Eli Kleinman, Supervising Chief Surgeon for the NYPD, showed me powerful film footage depicting his own remarkable escape from the plume of smoke and debris that engulfed him and others fleeing from the disaster zone as the towers fell. Witnessing his testimony is one of the most enduring memories of my visit. He also talked about the work of the City's various medical divisions tracking the health effects of 9/11 on their staff and his participation on the WTC health registry, the largest registry in the history of the country, which is now addressing the impacts of the disaster on service personnel. More generally we discussed the changes brought about by 9/11 in

relation to the counter-terrorism planning and preparedness of the City's top commanders and the importance of remaining actively alert to the possibilities of future terrorist events.

The Port Authority of New York and New Jersey was significantly affected by the events of 9/11. This organisation manages and maintains the bridges, tunnels, bus terminals, airports, PATH and seaport that are critical to the bistate region's trade and transportation capabilities. It includes its own police force as well as civilian staff. It not only owned the site on which the World Trade Centre was built but runs many of the transportation centres which continue to be key terrorist targets. I met with Lillian Valenti and Martin Duke (respectively Chief and Chief Medical Officer) of the Office of Medical Services who shared their personal and professional experiences of the day. Both had also been with the organisation during the attack on the World Trade Centre on February 26, 1993. They discussed the impact and response to the deaths of 37 Port Authority police officers and 47 of their civilian staff who all died on 9/11.

We talked about the importance of anniversaries (it was just before the 7/7 anniversary in London). I was impressed not only by their personal testimonies but also the sensitivity incorporated in the support services offered to bereaved families of their employees. These included the establishment of family assistance centres at airports, the deployment of a family liaison officer to each of the victims' families, staff debriefings and community-based support groups. Ms Valenti and Dr Duke also shared their experiences of dealing with the media after they were forced to release transcripts of emergency calls made on the morning of 9/11. Events like these were among the most traumatic for families, and over the last five years the Medical Services Office has seen highs and lows at key points reflecting the continuing effects on staff.

Strategies for Community Support after 9/11

- **Family Assistance Centres (FACs)**

Having been involved in UK planning for the establishment of family assistance centres after disasters, I was particularly keen to learn from those in New York and New Jersey who helped to set up and run FACs after 9/11. Centres were set up both in New York and New Jersey and it was especially helpful to hear the logistics and operational issues discussed in detail by those with first hand experience.

In the weeks and months following the disaster, families directly impacted were offered information and referral services at Family Assistance Centres like the one located in Liberty State Park in Jersey City. These services were delivered by human service agencies - local clinicians and specialists working with volunteer and professional disaster relief agencies - who staffed the centre. Disaster responders from the National Organisation for Victims Assistance (NOVA); the American Red Cross; the Salvation Army; the Federal Emergency Management Agency (FEMA); and other volunteer relief agencies, provided on-site crisis counselling and support services every day.

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

In New York a Family Assistance Centre was set up less than 24 hours after the attacks. It quickly became a focal point for the many thousands of people seeking news of missing loved ones. Its location changed a number of times over the following days, but eventually, once a more functional location with a suitably large exhibition space was provided at Pier 94, it became not only a place

for collecting information but also a one-stop shop for the full range of information and advisory services required to respond to the emerging needs. As well as the FAC, which focussed on the identification of the missing and services for bereaved families, over time a second facility - the Disaster Assistance Service Centre - enabled people more broadly impacted to access a full range of human services including income support, food stamps, medical assistance, case management, and job placement.

- **Federally Funded Outreach Programmes**

As well as these assistance centres, 9/11 sharply raised awareness that it would be necessary to increase local capacity for community-based outreach interventions. Project Liberty (in New York State) and Project Phoenix (in New Jersey) are two examples of federally funded programmes initiated in the aftermath of 9/11 to alleviate psychological distress by providing supportive crisis counselling to individuals and groups affected by the disaster. Mike Labate and colleagues from the New York State Office of Mental Health discussed with me the parameters, funding mechanisms and procedures involved in managing the complex administration of their Project Liberty programmes. Having been involved in the development and implementation of disaster support programmes, it was especially helpful for me to learn from their experiences of dealing with such an unprecedented event and the conceptual development of new programmes at such short notice, especially given the existing cultural, administrative and financial constraints they faced.

The projects adopted the FEMA (Federal Emergency Management Agency) model of community crisis counselling. This de-emphasises the “mental health” feel of counselling in favour of a more informal, less structured and less clinical approach. The model stresses supportive listening, problem solving, and education about ‘disaster stress’, coping skills and public information, as well as assessment and referrals as necessary. Rather than just using mental health professionals, the FEMA model also uses ‘paraprofessionals’ as primary responders, individuals who are community based, with a range of training and no particular background in mental health or human services. Addressing the fact that most people do not seek mental health services in the aftermath of disasters, the model adopts an outreach approach that takes crisis counselling to them where they are rather than waiting for them to come forward.

Project Liberty offered various face-to-face outreach, crisis counselling and education services. The programme helped disaster survivors to understand what was happening and how they were reacting, to think about options, and to find people or agencies that could assist with disaster-related problems. At the heart of Project Liberty's support activities were the values of hope, respect, safety, excellence and recovery. The aim was to help individuals recover from their psychological distress and regain their pre-disaster level of functioning.

Gail Wolsk and Ali Gheith of the New York City Department of Health and Mental Hygiene, Office of Mental Health Disaster Preparedness and Response gave me examples of how these principles were being applied through Project Liberty programmes. After three years, more than 1.3 million New Yorkers had received free, confidential, face-to-face crisis counselling services. More than 100 mental health agencies partnered with Project Liberty to provide services in their communities.

One example of a Project Liberty-funded project is the Family Assessment and Guidance Programme, a five-year initiative providing supportive interventions to affected fire-fighter families. Professor Grace Christ, of Columbia University’s School of Social Work is director of the programme and has been studying factors affecting the recovery of families from the disaster. After the numbed first year of chaos and uncertainty, and a second intensely painful year experiencing loss, she found that for families studied the third year was generally one of reconstitution and

reordering relationships, though still with painful reminders. Outreach has recruited bereaved families requiring more intense individual work and it was good to learn about the positive outcomes of the close and collaborative relationships between the Programme and members of the Fire Department's Counselling Unit. They talked with me about their educational projects, such as parent training for widows, a bi-monthly newsletter, activities for children, and family workshops. Members of the Unit commented on how recovery remains a long term goal, given the prevalence of the anniversary effect, and the fact that for many the impact of 9/11 is only now starting to be felt.

Project Phoenix arose as New Jersey's channel for the variety of federally-funded assistance made available following the disaster. Fortunately New Jersey had developed and implemented a formal disaster mental health plan prior to September 11. Professionals in each county had participated in extensive preparedness activities such as disaster drills and training programmes and had prepared educational materials for use during an emergency. Renee Burawski, Director of Information & Referral and Disaster Mental Health Services discussed with me the work carried out by the New Jersey Mental Health Association in responding to the disaster. This started with running a helpline but has since extended to include a broad range of training, intervention programmes, and further preparedness strategies for disaster mental health.

Through Project Phoenix services were offered at no cost to a range of impacted community groups: families of victims, New Jersey residents who worked in the twin towers, people who witnessed the disaster, hospital personnel who treated or waited to treat survivors, businesses, and people who were made unemployed by the disaster, Arab-Americans, children, military families and Latinos who worked near the site. The project also extended stress management services to first responders and crisis counsellors themselves, to guard against secondary stress. Public education and information was provided to schools, law enforcement agencies, business and the clergy. In addition, county providers created hotlines and worked with various other agencies to coordinate the provision of services.

The Families GOALS (Going On After Loss) Project is one example of a programme funded by Project Phoenix. It was started by a group of mental health professionals specialising in loss, trauma and crisis intervention for families and children. As well discussing this with Renee Burawski, I met with Nicci Spinazzola, co-author of the programme, and facilitators Barbara Maurer and Diane Travers who told me how the project has been providing a unique set of services in the areas affected by 9/11. These include family support groups which enable parents and children to talk about the ways in which they were impacted by the events, producing a workbook and video for schools to assist them in addressing terrorist-related concerns, and training other professionals on developing further groups for complicated bereavement.

The New Jersey Disaster and Terrorism branch of the Division of Mental Health Services is now developing a credentialing system for future disaster responders. Consultant Dr Monica Indart discussed with me how they are building on a pilot project and developing the scope, ethical standards and other parameters in a pioneering piece of work for the country. This will be of great interest to us in the UK who are also starting to develop similar accreditation schemes and we agreed to share experiences and keep in touch.

- **Self-Help Groups**

A further aim of my fellowship was to learn about community-based support and self help/family support groups after disaster. My meetings highlighted a number of self-help based approaches to disaster recovery after 9/11. For example, in addition to the counselling services offered by Project Phoenix's outreach teams and the participating community mental health organizations, New Jersey promotes peer-based support as a valuable resource in the disaster recovery process. The

'neighbour-helping-neighbour' idea has been at the heart of Project Phoenix's mission and has been a key model of crisis counselling.

A number of self-help groups specific to the September 11th disaster formed after the disaster. Through Project Phoenix I learned about New Jersey's online Self-Help Group Clearing House, a comprehensive guide to local community, national and online support groups. The clearing house helps people find and form support groups and includes information on how to start a community self-help group.

The principles of self-help, empowerment and community-led recovery underlie the Disaster Community Support Network established in Philadelphia by Dr Mark Salzer of the University of Pennsylvania. He has developed a programme and organisational structures for enabling a community support network and meetings to be initiated in the aftermath of disaster in order to facilitate individual and social recovery. I had read of his work on the internet and met with him to discuss these principles and his model. I particularly like the emphasis in his work on the importance of acknowledging community resilience and the values of self-determination and mutual support. Drawing on psychological and sociological perspectives as well as our professional experiences of support groups, we discussed the practical implications of community-based self help and advocacy and the value of including grass roots recovery strategies in disaster planning and response.

- **Specialised Trauma Treatment and Training**

As well as the crisis interventions initiated through Projects Liberty and Phoenix, 9/11 highlighted the likely increase in longer term mental health problems or 'surge capacity' that would impact on local resources for providing treatment for serious and chronic mental health problems and disorders. Initial studies of the mental health consequences of 9/11 found significant rates on new-onset PTSD in those directly and indirectly exposed in New York as well as further afield, leading to the prediction that there would be an increased need for evidence based treatments in greater New York (Marshall et al, in press). Dr Randall Marshall of The Centre for the Study of Trauma and Resilience (a unit created in response to the epidemic of trauma and grief-related problems among those affected by the attacks of 9/11) spoke with me about the work he and his colleagues have done in response to the epidemic of trauma and grief-related problems that have arisen. In the three years after the attacks they provided training in specialized trauma treatment (prolonged exposure therapy and complicated grief therapy) to more than 1500 community practitioners, and also developed an ongoing research and treatment programme for 9/11 victims with PTSD. Their work has expanded to include many research efforts in the areas of grief, psychological trauma, and education and training.

Two key points were highlighted for me by the work of Dr Marshall and his colleagues, firstly the importance of acting on opportunities to expand existing research and service paradigms in confronting the mental health challenges thrown up in the aftermath of disasters and, secondly, the importance of developing evidence-based strategies and treatment models. Bridging the gaps between research and practitioners, they have commented 'Service researchers will have to form partnerships with governmental and philanthropic agencies that are mandated to respond to community disasters. Researchers can play important direct and indirect roles in trying to influence providers toward greater accountability (i.e. program evaluation) and inspire all stakeholders to want to contribute to humanitarian knowledge that can benefit future disaster victims' (Marshall et al (in press)).

The importance of linking research and practice in disaster management arose again in my meeting with Professor James Halpern of the Institute for Disaster Mental Health, University of New York at New Paltz. The Institute was founded in 2004 to prepare students, community members,

paraprofessionals, and professionals in the helping fields to care for others following a disaster using evidence-based disaster mental health interventions, content, and skills. I was able to talk about the work I have done trying to bring together researchers and practitioners through the Disasters Study Group I set up in the UK and Professor Halpern discussed his programmes which prepare graduates to become certified responders for the American Red Cross. This summer Professor Halpern publishes a new textbook on disaster mental health which links theory and practice and which will provide an informative and practical contribution to our field.

Involving the Community in Future Preparedness & Response.

A further aim of my Fellowship was to learn about the role of the community in future planning and response activities. I have for some time been interested in comparative approaches to citizens' involvement in emergency planning and preparedness activities. In the US, where there is a much higher incidence of natural disasters, a culture encouraging citizen responsibility for their own safety during large scale emergencies seems more prevalent than in the UK. I had learned from the internet for example about family and community disaster preparedness planning as promoted by organisations such as the American Red Cross and discussed these with representatives such as Rowland Hill, Director of Health & Mental Health Disaster Services in Greater New York. In the UK, by contrast, the emphasis and expectation has traditionally been much more on emergency responders being available and taking control, though colleagues in the British Red Cross are actively working on ways to engage citizens in civil protection activities.

When I met with Lauren Ginsberg and her colleagues from New York's Office of Emergency Management we discussed how citizens' involvement in personal and community preparedness is being promoted. Since 2003 the Ready New York preparedness campaign, for example, has outlined tips and information to help local citizens respond to emergencies. Our emergency planners could learn from the detailed series of leaflets that have been produced focussing on emergency preparedness in relation to specific hazards and for differing community groups. Some of those I spoke with during my visit had acted on this and referred to their own and departmental plans for responding to an emergency. I was impressed with the work also being done to develop Community Emergency Response Teams (CERT) in New York. The programme aims to train neighbourhood and community-based volunteer teams to inform, educate and train their neighbours on disaster preparedness and assist in local response to disasters by supporting emergency personnel and other agencies. In June 2006 42 teams had been trained around New York City.

At the same time planners and others acknowledged that more needs to be done. Their comments reinforced the findings of a report recently produced by the Department of Homeland Security which found that while States and cities in hurricane zones generally have better plans to deal with disaster than other regions, the nation's overall level of preparedness is still far from sufficient (Lipton 2006:10). It was also suggested that the colour-coded terror alert system (ranging from green to red) is regarded rather cynically by many people. Some criticise it for being unhelpful and more a political gesture or 'lip service' than really addressing public safety. This was of particular interest to me given that during my visit the UK announced plans to introduce a similar new warning system to alert the public to terrorist threats!

Although a developing concept within emergency planning is the notion of individual and community resilience, it has become clear through my research and discussions that there is still a long way to go in understanding what this really means and how it can be achieved in practice. This is an area where continued exchange of information and experiences across the Atlantic will no doubt be helpful.

Walking around New York reminded me of how diverse contemporary communities are today and how this must be reflected in disaster planning and response. Peter Gudaitis, Executive Director of

New York Disaster Interfaith Services (NYDIS), told me about the work of this faith-based federation of service providers and charitable organizations who today work in partnership to provide disaster services. The organisation grew out of 9/11 after clergy and faith-based agencies responded to Ground Zero and assisted in the rescue, relief and recovery efforts. From this reactive and improvised approach the faith communities realised that better planning and preparedness was needed and have since developed a communication network of faith-based disaster service agencies. This coalition now coordinates various faith-based readiness, response and recovery activities in New York City.

In terms of engaging the community in emergency management I learned that the responder community includes not just those still working but also those who might volunteer in disasters even after retirement. During my visit to New York's Police Department I met with Lieutenant Michael Ryan who told me about the Retiree Mobilisation Plan which has evolved since 9/11. In response to the outpouring of offers of help from retired members of the service after the attacks, it is designed to involve retired members of the service after future catastrophic events. This programme struck me as a most useful and innovative way to engage those who have left the service but still retain valuable experiences, interest and skills which can be drawn on at a time of need. The retirees' enthusiasm for remaining connected with the service as a 'family' reminded me of similar comments made by retired fire-fighters I met who also described their links with the fire service as like being part of a family, and spoke about maintaining a connection with their job that 'never leaves you'.

As with the UK, members of the emergency services have traditionally been hostile to 'mental health' professionals from outside of their own community addressing them in the aftermath of incidents. Within the emergency response community in New York, the principle of peer-based strategies has been adopted as a key element in community-based approaches to psych-social support. I was able to discuss these with peer counsellors from within both the Fire Department's Counselling Service Unit and NYPD's Early Intervention Unit, both of which extended support programmes to first responders in the aftermath of 9/11.

Developments in Emergency Planning and Training

There is no doubt that the events of September 11 changed many general attitudes and specific practices relating to emergency planning, training and security procedures. Any visitor symbolic sites such as New York's Statue of Liberty, the Empire State Building and Philadelphia's Liberty Bell Centre is made explicitly aware of changed approaches which have been introduced such as rigorous security checks.

Those involved directly in first response and the emergency services have also learned lessons in relation to plans and protocols and been particularly active in addressing ongoing threats of future terrorist attacks. After last year's London bombing, for example, New York's emergency response community examined its own plans for dealing with subway emergencies and the challenges they would face in evacuating people in an emergency. In a City of 8 million people it would remain difficult to respond during a large scale emergency, though much effort continues to be put into evacuation and response protocols should a future terrorist event or hurricane hit the City.

My discussions also focussed on examples of disaster training that are backing up plans in New York and New Jersey. Again there has been national momentum and funding granted to prepare the country for future events such as terrorist attacks. Professor Jack Herrmann discussed with me the training curricula he has been developing for helping New York State's hospitals, public health workers and other disaster responders understand bio-terrorist attacks and their psychosocial consequences. The curriculum resulted from a review he conducted of county mental health plans

which highlighted the gaps between expectation and response capability. Mapping the new curriculum against professional competences, the training aims to complement planning initiatives in order to keep disaster mental health responders actively engaged and ready to respond in the event of large scale emergencies.

Dealing with CBRN (chemical, biological, radiological or nuclear) events, including pandemic flu, is currently of major concern to emergency management communities both in the US and UK. My meetings reinforced for me that in the UK we have much more to do to integrate mental health and behavioural components into our training and plans. This was further highlighted for me in discussions with Steve Crimando, who demonstrated the training he has developed as part of the New Jersey Preparedness Training Consortium, a partnership comprised of many of New Jersey's healthcare organizations with specialist experience in counter-terrorism. In his training he makes the point that 'the ultimate tool of the terrorist is not chemical, biological, nuclear or radiological - it is psychological. Terror is fear'.

Emergency Management includes Fear Management

A theme that emerged in a number of my meetings was the phenomenon of fear in the wake of past and present events and the role of fear as an ongoing aspect of terrorism. Some of our discussions focussed on the way in which general cultural attitudes within society can influence both personal and collective responses to terrorism and the extent to which fear remains within our major cities which have been the target of terrorist attacks.

In London after the July 7 bombings a website which was set up to give Londoners a voice quickly received overwhelming support. It carried the message 'We Are Not Afraid' which became identified with a defiant message of public solidarity and defiance to the bombers. The website's designer, Alfie Dennan said the site had become a symbol for people to show solid support for London and commented that "It is very unusual for Londoners to be afraid. They are showing that they are not going to react to this by fear." On the first anniversary of the bombings, the 'We Are Not Afraid' logo appeared again (this time on t-shirts and brightly coloured wristbands), having been adopted also by young Muslim men wishing to counter negative stereotypes of their community and raise money for charity.

Some of my colleagues in New York responded to my accounts of this by saying 'We *are* afraid'! They added that recent reports of terrorist plots to attack key transit routes and high profile (but only random) baggage checks on the subway and at airports have done little to calm anxieties for some. It was suggested that perhaps New Yorkers may be more open about saying they are afraid than in London since feelings might be more openly discussed and I agreed that there are also many in London who have found it difficult to travel without fear on the underground after July 7, despite talks of the celebrated 'London Spirit' both in Churchill's time and today. (Given this it was interesting to hear how the branding of Project Liberty included the tag: 'feel free to feel better', directly addressing the stigma associated with acknowledging feelings like fear and seeking mental health support.)

So what have I learned about what more can be done? As a sociologist, much of my work has been about highlighting for emergency managers and first responders the importance of understanding the role of emotions and human behaviour in order to plan and respond realistically and effectively to disasters. I think much of our current planning still fails to take account of such behavioural elements, in part because of fears of mass panic and social disorder. The testimonies I have heard about responses in the US on 9/11 and the resilience of communities there has highlighted the potential for proactive responses in the face of traumatic events and reinforced the lessons I had learned from my own disaster research and experiences that show how most responses are in fact pro-social, ordered and cooperative.

But this is only part of the story. I am thinking about future threats and concerns about potential unprecedented disasters such as extensive outbreaks of smallpox, pandemic flu or deliberate CBRN-type events. These demand we look realistically at the likely scenarios for dealing with such hazards and their psycho-social fallout, and at the potential role that a range of behaviours, including fear, mass panic and disorder could play. Emergency management of the future must include fear management and how this can be addressed before, during and after such events. Fear here includes the fears of emergency managers to address human behavioural and emotional factors as well as the reactions of the community in an emergency based on widespread chaos and uncertainty.

Through my travels I learned about how New Jersey responded to the anthrax attacks that occurred one month after 9/11 with extensive psycho-social repercussions. I also learned about innovative plans and strategies being developed which involve working directly with the public to demonstrate ways of addressing such new challenges. They are based on the principle that public engagement in terrorism/emergency preparedness and planning is both beneficial and achievable and are enabling community residents to play a role in developing realistic and effective protective strategies. These examples and lessons are among the key messages I will be taking home.

'Failure to involve the public as a key partner in the medical and public-health response could hamper effective management of an epidemic and increase the likelihood of social disruption. Ultimately, actions taken by non-professional individuals and groups could have the greatest influence on the outcome of a bio terrorism event' (Glass & Schoch-Spana 2002:217)

Conclusion

This report has only skimmed the surface of all that I learned on my Fellowship travels. Over the next few months I will be consolidating these in the ongoing work I do as a trainer, researcher and consultant in trauma and disaster management. Here I present just some examples of key lessons which have been learned or reinforced for me during my time in the US:-

- The ripple effects of catastrophic events such as 9/11 and Hurricane Katrina are more extensive than we have really experienced in the UK in recent years. We have done much in the UK to improve the support we make available to bereaved families and survivors but can learn much from the US's experience of providing disaster assistance services to a much broader range of potential victims in terms of economic, social, occupational and other effects of large scale disasters.

- Community cohesion and social support are critical to psychological recovery after a disaster. In the case of 9/11 the traditional support structures within communities – families, schools, workplaces and mental health providers – were also devastated so strategies also need to be about bolstering those support services in order to thereby help those most directly affected.

- Understanding and addressing the behavioural and emotional dimensions of disaster is crucial if emergency response and recovery is to be effective. We have for some time talked about 'integrated emergency management' in the UK but there are more lessons to be learned and shared with our colleagues in the US with regard to collaborative multi-agency planning, preparedness, training and meaningful exercising.

- 'Necessity is the mother of invention'. I have learned about many examples where innovative approaches to post-disaster support were developed in limited time and in a way that overcame traditional bureaucratic and other constraints. A broad range of psycho-social

support strategies is appropriate after disasters. Useful precedents were established after 9/11 through the funding of extensive community based as well as site-specific outreach services.

- In both the US and UK we tend to focus more on the immediate aftermath and short-medium term response. From a mental health perspective there is sometimes an overemphasis on a) pathological reactions and b) accepted paradigms for intervention which may not be evidence-based or most effective. More longer term, grass roots and non-'mental health' type approaches need also to be acknowledged, considered, implemented and evaluated using appropriate user-based methods.

- Our training and planning for future risks and threats such as CBRN attacks must address more comprehensively the associated psychological and behavioural effects of such 'silent' disasters. Plans and training must address behavioural responses to such scenarios which may include fear, uncertainty, panic and health-care seeking behaviour.

- Local disasters plans must include arrangements for family assistance centres and other facilities which may be necessary for meeting the range of needs generated by an incident. In a catastrophic event there are likely to be a number of centres established; the political, logistical, bureaucratic and economic challenges associated with these seem to be universal.

- Self help support groups are a key element in disaster recovery. The ways in which these are initiated and organised varies according to the unique characteristics of any disaster, those affected and the nature of organised support strategies in place. Recovery strategies should include providing opportunities for people to make choices about how, when and the ways in which they can best access support for themselves and others after disaster. This may include referring to either or both organised/facilitated support and/or grass roots, community-based initiatives.

While preparing for my travels one of my contacts sent me a quote from Winston Churchill which she said had meant much to her after responding to 9/11. It meant a lot to me too while reflecting on the special opportunity I have been afforded through my Fellowship. I end my report with this quote as it also especially relevant to the theme of preparedness that underlies this work and the chance we may be presented with to turn future disasters into opportunities and to make a positive difference:-

"To every person there comes in their lifetime that special moment when you are figuratively tapped on the shoulder and offered the chance to do a very special thing, unique to you and your talents. What a tragedy if that moment finds you unprepared or unqualified for work which could have been your finest hour."
-Sir Winston Churchill

Appendix 1

My Winston Churchill Travelling Fellowship
A Summary of My Mission & Goals:

Project Title: *Lessons Learned for Community Support After Disasters*

Dr Anne Eyre

About the Fellowships

The Winston Churchill Travelling Fellowships are funded by the Winston Churchill Memorial Trust (http://www.wcmt.org.uk) which was established after many thousands of people, in respect for the man and grateful for his inspired leadership, gave generously after his death in 1965 to a fund. The Fellowships are to enable men and women from all walks of life to acquire knowledge and experience abroad. In the process, they gain a better understanding of the lives and different cultures of people overseas and, on their return, their effectiveness at work and their contribution to the community are enhanced greatly. Applications are assessed on the extent to which they will benefit the potential fellow's community and the UK on return. The Fellowship also provides an opportunity to participate in mutual exchange of ideas and experiences with people and communities outside of the UK. From over 750 applications this year, 100 were awarded.

My 2006 fellowship has been awarded within the category of 'Emergencies and Disasters'. Under the general heading I devised of 'Exploring Lessons Learnt for Community Support after Disasters', my aims are as follows:-

- To explore comparative experiences of community impacts of disasters & approaches to psycho-social support strategies

- To discuss lessons learnt, plans & training models for the establishment of Family Assistance Centres following disasters

- To review implications for setting up future family support groups

How I Propose to Achieve my Aims

My aims will be achieved through a series of meetings, interviews, informal discussions, & observations with key individuals and representatives from organisations involved in previous response, current planning & training for future events. I will conduct these while being based in New York City from June 22-July 20 2006.

Particular, but not exclusive, reference will be made to terrorist-related incidents. This will include sharing lessons from the experiences of the London Bombings last year (7/7) and the September 11 attacks of 2001 (9/11). If possible I wish to meet with those directly involved in setting up the first Family Assistance Centres (FACs) after the September 11 attacks as well as those on the receiving end of organised support. This includes emergency responders, survivors and members of bereaved family support groups. There may also be opportunities to share lessons learned from other recent events such as the Asian Tsunami of 2004 and Hurricane Katrina. As detailed below, I am keen to share lessons after having helped to advise on the management of the first FAC in the UK last July (London) and have been involved in helping to coordinate support for UK families after the Tsunami.

Goals and Outcomes

The overall goal is to discuss approaches to psycho-social support for individuals and communities affected by disaster. This will be achieved through opportunities to meet with a range of personnel from various organisations and professional/personal backgrounds who have been/are involved in work that spans the various phases of disaster, from planning and preparedness to response and recovery. By the end of the period of travel I hope to have been able to:-

- meet with and discuss general **lessons and experiences** of psycho-social impacts and responses with a range of personnel involved in the management of recent and future disasters

- discuss principles, guidelines and approaches to **planning and training** for meeting the psycho-social needs of those affected by future disasters

- examine approaches to **credentialing/accreditation** of those involved in psycho-social support programmes after disaster

- discuss in particular the lessons learnt from experiences of setting up **family assistance centres** in the aftermath of events and the implications of future planning, training and response.

- meet with people who have been **bereaved and/or are survivors** (including those involved in the emergency services) from events such as 9/11 and learn from them what has been helpful and unhelpful after disaster

- gain an understanding of different types of **community support networks** that might be set up after disasters, including community-based/service-led networks and user-based, self help support groups

- share **experiences from the UK** in relation to our approaches to psycho-social planning, response and training, including in the areas of FACs and family support groups

How I Propose to Use my Knowledge and Experience

The Churchill Trust asks its Fellows to produce a short written report upon their return which discusses lessons learned and recommendations. Fellows are also expected to disseminate the results and findings of their overseas project as widely as possible. I plan to do this through my ongoing work in training, research and consultancy as well as through writing for publication in academic and practitioner journals.

My Background and Interests

I trained as a sociologist (PhD Liverpool University, 1989) and over the last fifteen years or so have developed a special interest in the psycho-social dimensions of major incidents/disasters. This arose partly out of the UK experience of a decade of disasters in the 1980s, a series of humanly-caused events such as transport accidents, terrorism and major fires. I lectured on the first university degree programme in disaster management in the UK until five years ago. Since then I have worked as an independent consultant providing research, training and consultancy services to various organisations involved in planning and responding to incidents involving sudden and traumatic death. This includes participating on a police-led committee which developed national guidelines for family assistance centres in the UK in 2005; these were used in establishing the first such centre after the London bombings last year.

Over the last year I have also been working with the British Red Cross as Programme Coordinator for the Tsunami Support Network (www.tsunamisupportnetwork.org.uk). This programme was funded by the UK government to provide medium/longer term support for those UK citizens who were bereaved and/or survivors from the Asian Disaster of December 2004. Our work included setting up a website, producing newsletters and facilitating the establishment of self-help support groups.

I am also Vice Chair of Disaster Action (www.disasteraction.org.uk), a charity set up in 1991 by survivors and bereaved people from major disasters. It is an independent advocacy service that represents the interests of those directly affected by disaster. All our members have direct experience as people who have been either bereaved and/or are survivors of disasters affecting UK citizens. Our collective experience spans disasters over forty years. My interest in this field was initially generated by my own experience as a survivor of the Hillsborough Football (Soccer) Stadium Disaster in 1989.

Appendix 2

Itinerary: List of People I Met During My Fellowship Visit.

(These are presented in the order in which I met them)

Representatives of New York Fire Department (with special thanks to Malachy Corrigan, Director of the Counselling Services Unit who arranged the schedule for me):- Captain Frank Leto (Deputy Director Crisis Management, Claire Cammarata & Dianne Kane (Clinical Directors of the Counselling Service Unit), Kim Ahearn (Program Director Kids Connections) and various members of the counselling staff/peer support team including John Marchini, Ralph Esposito and Art Tracy

Peter Gudaitis, Executive Director, New York Disaster Interfaith Services

Gail Wolsk (Director) & Ali Gheith (Coordinator of Population Based Resilience), Office of Mental Health, Disaster Preparedness and Response, City of New York

Leslie Slocum, Press & Public Affairs Officer, British Consulate General

Dr Richard Shadick, Director of the Counselling Centre, Pace University

Lauren Ginsburg (Assistant Coordinator, Planning & Preparedness), Sharon Hawa (Community Coordinator, CERT Programme Manager), Office of Emergency Management, City of New York

Professor Jack Herrmann (Programme Director, Disaster Mental Health, University of Rochester and Disaster Mental Health Consultant, American Red Cross, Northeast Service Area) & Rowland Hill (Director, Health & Mental Health Disaster Services, American Red Cross in Greater New York)

Dr Randall Marshall, Director, Trauma Studies and Services, New York State Psychiatric Institute; Associate Professor of Clinical Psychiatry, Columbia University College of Physicians and Surgeons

Professor James Halpern, Director, Institute of Disaster Mental Health, State University of New York at New Palz

Lillian Valenti (Chief) and Dr Martin Duke (Chief Medical Officer), Office of Medical Services, Port Authority of New York & New Jersey

Representatives of New York State Office of Mental Health (with special thanks to Mike Labate, Director of Emergency Preparedness & Disaster Response, who arranged the schedule for me): Keith Simons, Deputy Commissioner, Office of Planning and Intergovernmental Affairs; Carol Lanzara and Sheila Donahue, (Center for Information Technology and Evaluation Research) & Robin Goldman (Counsel).

Representatives of New York Police Department (with special thanks to Detective Ben Pistilli who arranged the schedule for me):- Deputy Chief George Anderson (Executive Officer, Personnel Bureau), Sergeant James Andruszkewicz (Early Intervention Unit), Lieutenant Michael Ryan (Director, Retiree Mobilisation Programme), Dr Arthur Knour (Director Psychological Evaluation Unit), Dr Eli Kleinman (Supervising Chief Surgeon)

Steven Crimando, Director of Training, Disaster & Terrorism Branch, Division of Mental Health Services, State of New Jersey & Managing Director, Extreme Behavioural Risk Management

Amy Dorin (Senior Vice President), Ellen Stoller (Assistant Vice President) & Abram Sterne (Director-Performance Measurement & Outcome Research), Behavioural and Health Services, FEGS Health & Human Services System

Dr Mark Salzer, Centre for Mental Health Policy and Services Research, University of Pennsylvania

Professor Grace Christ, School of Social Work, Columbia University

Diane Travers, Centre for Prevention & Youth Development, Mental Health Association of Essex County

Barbara Maurer, private consultant and member of the Board of Directors, Association of Traumatic Stress Specialists

Renee C. Burawski, Director of Information and Referral and Disaster Mental Health Services Mental Health Association in New Jersey

Dr Monica Indart, Principal, Commonweal Services, Mental Health Response Emergency Coordinator for the NJ Division of Mental Health Services, Disaster and Terrorism Branch

Nicci Spinazzola, Director of the ALLIES Adolescent and Family Services Department, New Jersey

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