

A Critical Evaluation of Crisis Support Arrangements in a UK Local Authority

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This article explores crisis support work in a UK local authority and identifies significant issues for management and practice. It is based upon three elements: a detailed search of relevant literature; analysis of official guidance; and fieldwork with crisis support workers, their managers and other professionals in partner agencies. The latter was based upon 44 interviews and the observation of key meetings over a 3-year period and includes a review of Crisis Support Team deployment at three major incidents between 2004 and 2007. Crisis support practice had much to commend it in terms of preparation, continuity, flexibility and proactive engagement with other agencies. Deployment to a wide range of 'minor' incidents was valuable in maintaining skills, motivation and inter-agency familiarity between major incidents. On the other hand, significant and sometimes serious issues emerged in terms of capacity, inter-agency communication and co-ordination and fragmentation of overall incident response.

1. Introduction

In the United Kingdom, local authority 'crisis support' teams aim to provide structured help to the bereaved and survivors in the immediate aftermath of major emergencies. However, notwithstanding recent review and reform of response to disaster victims and official acknowledgement of the crisis support role, the latter has received little scrutiny. This article reviews relevant literature and guidance and draws on fieldwork exploring crisis support through three major incidents between 2004 and 2007. The article identifies key issues around the crisis support role in UK emergency response and suggests that significant developments within professional social work and emergency response raise questions that have, to date, received minimal attention. The paper is set out as follows:

- A brief outline of crisis support work and the challenges it faces.
- An outline of theoretical concepts informing the study.
- A brief review of research methodology and data collection used in the study.
- Outline of key findings of the study.
- Concluding indication of implications.

2. Crisis support and its challenges

2.1. Historical background

Since the late 1980s, the deployment of psychosocial professionals after UK disasters has become common (Brook, 1990; Hodgkinson & Stewart, 1991; Johnston & Beeson, 1993; New-

burn, 1993). Satisfactory management of the *immediate* aftermath, however, remained elusive. During the 1990s, evidence accumulated that survivors and relatives were sometimes treated insensitively, inefficiently and sometimes even callously (Coleman, Jemphrey, Scraton, & Skidmore, 1990; Davis & Scraton, 1997, 1999; Scraton, 1999; North, 2000; Clarke, 2001). More recently, psychosocial response in the immediate aftermath to the Ladbroke Grove rail crash was characterized by role confusion and uncertainty (Harrison, 2000).

State responses to these problems took some time in developing, but initiatives by the New Labour government elected in 1997 led to important changes in emergency planning and humanitarian response. In 2001, Lord Justice Clarke published the findings of a public inquiry into the treatment of victims of the 1989 *Marchioness* disaster. These reframed some needs of bereaved people – specifically around body viewing and post-mortem procedures – as rights, and elaborated key principles of support (Clarke, 2001). The Civil Contingencies Act 2004 generated new guidance around humanitarian response, but confirmed the local authority's lead role in rehabilitating communities. It also promoted the idea of local authority-led crisis support teams consisting of 'skilled, vetted, trained and prepared volunteers ... stand[ing] ready to be called together in the event of an emergency' (HM Government, 2007, p. 26). These teams, it was suggested, might assist in:

... explaining procedures and processes, keeping people informed, and letting them know the roles of the agencies involved; explaining common reactions to crisis and stress and helping identify where specialist help is

required; ... helping people access [other support services]; and fulfilling a listening role (ibid, p. 26).

Guidance contains little further discussion of crisis support work. A little more helpfully, academic and professional literatures suggest that the key task of early intervention should be to 'provide *practical, pragmatic* support in a sympathetic manner, to complement the input of friends and family' (Bisson, Brayne, Ochberg, & Everly, 2007, p. 1017, emphasis added). The aim is 'to orientate rather than to treat' (Scott & Stradling, 1992, Appendix D). Bereaved people may need support through a range of interventions: from the time of initial uncertainty through notification of death; post-mortem and other forensic procedures; viewings of the deceased; and inquests. Guidance states that the quality of support at this early stage is important for longer term well being (HM Government, 2007).

2.2. The crisis support task in context

If orienting victims is at the heart of effective crisis support, workers must first orientate themselves – that is to say, they need to *make sense* of the emergency. This is not always straightforward. Incidents and their aftermaths need to be understood at a number of levels. First, at a 'micro' level, the characteristics and direct impact of the incident itself will help to determine practical and psychological needs and the challenges in meeting them. For example, sites may be open or inaccessible, there may be many casualties or few, deceased victims may be easy or difficult to recover or identify. Impact indeed may be so severe that responding agencies are damaged, as after the sinking of the Baltic ferry *Estonia* or the attacks of 9/11 (Horner, 1998; Kendra & Wachtendorf, 2003). It may also extend far beyond the immediate site (Lennquist, 2004b). Given that UK preparation and response are based at local level, this is of obvious potential significance.

Second, at a 'macro' level, the specific and broader social contexts within which incidents occur need to be understood. These set the conditions within which victims and other stakeholders attempt to make sense of their experiences, and within which society makes sense of *them*. Disasters are socially situated events, originating in pre-existing assumptions and practices (Turner & Pidgeon, 1997). They may act as 'focusing events', 'dramatically highlighting policy failures' (Birkland, 2004, p. 181). In short, they are *political*.

Questions are asked that previously went unformulated and the answers can shed floods of light on what everyone previously failed to attend to and took for granted ... Such civic moments can be moments of intense contestation (Lukes, 2005, p. 1).

Significant issues may arise here for crisis support. First, blame may be attributed from an early stage to corporations and state agencies, some of which may be involved in the

response. Organizations can waste time attending to public relations and playing blame games (Davis, 2006). Second, victims may be presented as responsible for their own fates. Victims are often reminders of uncomfortable questions. In western society 'our primary myths emphasize justice and control, optimism and a positive outlook ... There is little place for losers' (Janoff-Bulman, 1992, p. 154). In the contested aftermaths of disaster, organizations may be tempted to target victims specifically, notable examples include the UK's Hillsborough disaster and the Canadian Westray mine disaster (Coleman et al., 1990; McMullan & McClung, 2006).

Third, between the micro and macro levels lie 'meso', or organizational factors that need to be understood. Responder organizations need to reflect on the dynamics within and between themselves that may promote or detract from effective response. These factors are the main focus of this paper and it is to these that we now turn.

3. Theoretical and empirical issues in organizational response

Key factors shaping organizational performance after major emergencies include planning and preparation; capacity; continuity; flexibility and responsiveness; and inter-agency relationships.

3.1. Planning and preparation

Emergency plans may over rely on the predictive reliability of statistical models of risk, 'editing out' uncertainties, or representing partial or distorted data as if they are precise (Smithson, 1990; Blanco, Lewko, & Gillingham, 1996; Smallman & Weir, 1999). Voluminous documents may have a seductive appeal, encouraging the comfortable misapprehension that all contingencies have been identified and all necessary boxes ticked (Dynes, 1994; Lennquist, 2004a; Perry, 2004). Planning and preparation are better seen as ongoing processes than the production of a set of 'fixed' documents (Perry & Lindell, 2003). They should emphasize continuity, feedback and flexibility, orienting organizations towards the tasks of *how to plan*, *how to elicit and interrogate feedback* and *how to adapt responses to developing dynamics*. Planning and management, therefore, are not separable, but should 'supplement and complement each other' (Perry, 2004, p. 65). While the ultimate test is disaster itself, training and exercises are essential preparation (Baldwin, 1994; Andersen, 2003). Training helps disaster workers 'make sense' of 'the atypical events and reactions that typify the disaster experience' (Paton, 1996, p. 12). Where workers are 'readied' for the confusing realities of disaster and encouraged to adopt realistic 'schema', this may also reduce vulnerability to trauma (ibid). Exercises, carefully focused and reviewed, 'provide the forum or context to test the effectiveness of both the training program and the plan' (Perry, 2004, p. 66).

3.2. Capacity

Quests for 'efficiency' across public services may leave organizations with little 'slack' to respond to unforeseen demands (Rosenthal & Kouzmin, 1996; Boin, Lagadec, Michel-kerjan, & Overdijk, 2003). In health, for example, while hospitals used to have 'reserve capacity' with available theatres, beds and equipment, this is often no longer the case (Lennquist, 2004a). Corbacioglu and Kapucu (2006, p. 214) suggest that organizations need the flexibility to 'relax or eliminate other functions temporarily when needed', a requirement that will be difficult to meet when agencies are stretched to reach their 'normal' targets. The formation and training of crisis support teams may be seen in this context as unaffordable luxuries or diversions from pressing daily priorities (Smith, Lees, & Clymo, 2003).

3.3. Continuity

The 'continuity principle' emphasizes that pre-incident arrangements are crucial to post-disaster effectiveness (Dynes, 1994). Notwithstanding the specific problems attending unpredicted and overwhelming events, there are clear connections between pre and post disaster behaviour. At the simplest level, workers who are unfamiliar with loss and trauma in their daily practice, are unlikely, in emergencies, to suddenly become proficient practitioners. At an organizational level, if organizations communicate poorly in normal circumstances, they are unlikely during emergency suddenly to metamorphose into exemplars of good inter-agency practice.

A problem follows: how can planners ensure competence in major emergencies where personnel and organizations are unfamiliar with them? Major emergencies are relatively rare in most localities and even for emergency services personnel they may find themselves working in unfamiliar territory attempting to meet demands that are in themselves or through their scale and urgency, out of the ordinary. UK humanitarian response has relied on in-house social workers – workers who are assumed to have daily familiarity with loss and trauma and the humane, relationship-based practice demanded by such work. While continuity is assumed, however, recent trajectories of social work problematize this assumption.

Increasingly, social work is concerned with enforcing regulatory practices that underpin neo-liberal policy and ideology (Carey, 2008a, 2008b; Coffey, Dugdill, & Tattersall, 2009; Pollack, 2010). Consequences of the neo-liberal shift have included a sustained attack on the core skills and values of social work (Jones, 2001; Bisman, 2004); the commodification of caring (Dominelli & Hoogvelt, 1996); and a shift towards bureaucratized instrumentalist methodologies, applied within a tightening array of contracts, procedures and regulations (Blaug, 1995; Dominelli & Hoogvelt, 1996; Khan & Dominelli, 2000; Jones, 2001). Practice, it is argued, has been reconfigured through audit, towards meeting targets, sometimes 'at a high emotional cost to clients' (Munro, 2004, p. 1087). Statutory social work has become 'saturated

by the language and techniques of risk ... privileging metrics and administrative power ... [whilst] ... the plurality of rationalities, that in the "real world", organise practitioners' judgements and decisions are neglected' (Broadhurst, Hall, Wastell, White, & Pithouse, 2010, p. 1047). For Parton (2008, p. 254), 'the nature of practice and the knowledge which both informs and characterizes [are] increasingly less concerned with the relational and social dimensions of the work and more with the informational'. He argues that the 'byte-like' information required for the ICT databases that now rest at the heart of social work generates a culture that 'is not interested in meaning but in operationality' (ibid, p. 264).

It is perhaps unsurprising, in this context that social work morale has plummeted and deskilling has created an environment where 'stress and unhappiness ... [are] ... serious and pervasive' (Jones, 2001, p. 551). One recent survey indicated that 36% of social workers who responded would be considered as mental health 'cases' (Coffey et al., 2009). The national *Social Work Task Force* (2009, p. 29) noted that 49% of social workers worked longer than their contracted hours and that there was 'very strong evidence that the absence of effective management of workload ma[de] practitioners feel de-skilled, lower[ed] their morale and [could] lead to poor health'.

Dominelli and Hoogvelt (1996, p. 46) conclude that '[social work's] concern with ... adaptive responses to life situations has virtually disappeared'. Yet, although it is precisely this issue that should be at the heart of crisis support work, there is scant evidence that it has been recognized, or still less addressed in guidance or professional literatures. For example, although Lord Justice Clarke's (2001) public inquiry heard that social workers deployed to the Ladbroke Grove rail disaster were unable to respond appropriately through their own professed ignorance and inexperience in the areas of loss and trauma work (Harrison, 2000), this did not seem to inform his final report.

3.3. Flexibility and innovation

While it is generally best that emergency arrangements should not overly deviate from normal practice, disaster often proves too much for 'normal' ways of working and places a premium on improvisation (Dynes, 1994; Sellnow, Seeger, & Ulmer, 2002). Crisis literature has largely focused here on the problem that where organizations are reliant on bureaucratized, slow-moving processes they often prove incapable of dealing with the dynamic uncertainties of emergency (Lagadec, 2004; Corbacioglu & Kapucu, 2006). However, it may not only be the urgency of unfamiliar demands that requires deviation from normal viscous or intractable 'normal' operations. In some circumstances, normal practice itself may be deeply problematic. Failures after Hurricane *Katrina* were not merely procedural or administrative. They expressed historically entrenched and institutionalized assumptions towards poor and black people

(Gilman, 2005; Niman, 2005; Oliver-Smith, 2005; Ransby, 2006). Similarly, the attitudes of some police officers towards victims after Hillsborough were grounded in official and wider social and political stereotyping of football supporters and of Liverpool supporters, in particular. Both victim groups were, in terms of dominant 'common sense' and professional discourse, problems to be contained, potential threats to order and security (Scruton, 1999). When *normal* operating assumptions and practices are problematic and the intense strains of disaster highlight or exacerbate what are *regular* deficiencies, it makes no sense to attempt their replication in emergency. Here, the last thing a disaster victim needs is more of the same.

Whether organizations will be able to understand the need to suspend or discard procedures that are inappropriate or ineffective, and still less, whether they will be able to adopt new *ways of seeing*, is questionable. To do so, it will be imperative to digest the larger context, including the suffering of others (Molotch, 2005). Where junior and middle-ranking officials recognize the need to deviate from standard approaches they need to be accorded the latitude to improvise and will have to be confident that others, including superiors, will also see this 'bigger picture' (Corbacioglu & Kapucu, 2006). Unprecedented action may require 'a kind of panic of empathy that trumps organizational habit and individual postures' (Molotch, 2005 p. 2). Ultimately, *in extremis* what is needed is ambivalence to past practice (Kendra & Wachtendorf, 2003).

3.4. Inter-agency communication and co-ordination

Every major emergency gives rise to an 'incident organization: that is, a temporary configuration of otherwise disparate resources drawn from many agencies' (Smith & Dowell, 2000, p. 1154). Inter-agency working in the time conflated circumstances of disaster is rendered difficult by problems of communication (Boin et al., 2003). Reciprocal processing of information relies upon shared understanding. Without it, information that is significant to the sender may be inconsequential to the recipient, or *vice versa*. Trust too requires familiarity (Supermaniam & Dekker, 2003). The necessary confidence and understanding for co-operative working after disaster 'will grow through agencies working together and in this context the joint exercising of plans will help the process considerably' (Payne, 1999, p. 112).

In practice, however, disasters can produce misunderstanding, miscommunication, lack of co-operation and sometimes overt conflict. Difficulties in communication can result from inter-agency unfamiliarity, isolation and autonomous working practices (Auf der Heide, 1989; Quarantelli, 1994; Gillespie & Murty, 1994). Conflict over domains, power or resources can be significant. Agencies may be acutely aware of both the potential and the risk that media attention represents, choosing either to avoid other agencies in search of a high profile or minimizing risk by seeking to dilute responsibility across a number of agencies (Granot, 1997).

Information can be distorted within and between organizations to suit particular interests and hierarchies (Smallman & Weir, 1999). Crucially, organizations may be poor at 'listening', preferring instead to see incidents and the needs they generate within favoured frames (*ibid.*). To avoid these problems what is necessary is an 'environment in which co-operation and feedback can thrive' allowing responses to be adjusted as events develop (Hills, 1994, p. 8). Weick (1993) emphasizes the importance of respectful interaction, in which information from others is taken seriously, reporting to others is honest and individuals attempt to integrate their own perspectives with those of others. Individuals and organizations need 'to be open to valid information and take action to obtain it', even when it is inconvenient or uncomfortable (Corbacioglu & Kapucu, 2006, p. 215). This is particularly so where some victims are unable or less able than others, to challenge official accounts (Tucker, 2004).

In an important counterpoint to official exhortations to 'co-ordinate' and to 'integrate', Rosenthal, t'Hart, and Kozmin (1991, p. 212) argue that the prevailing emphasis on 'integration' is not only unrealistic, but *undesirable*. They emphasize 'the problem solving potentialities of polycentric approaches stressing interagency checks and balances' (*ibid.*, p. 213). On this view, cosiness between partners can lead to the minimization of differences. Polite interaction, as Smithson notes, 'trades on vagueness, ambiguity, non-specificity, and even distortion' (1990, p. 225). Crisis support needs to be sufficiently assertive to ensure the salience of humanitarian priorities within the overall response. This is especially the case given recent concerns that military-based 'command and control' remain 'alive and well' (Supermaniam & Dekker, 2003, p. 313) and towards a potentially authoritarian over-emphasis on the threat of terrorism and anti-social behaviour (Alexander, 2002; Perry & Lindell, 2003; O'Brien & Read, 2005). It is also important given evidence that in some 'everyday' working relationships between social workers and police officers there can be a tendency by the latter to perceive themselves as the 'lead agency' (Garrett, 2004).

4. Research methods and data collection

4.1. Research Process¹

It is important to recognize the value of evidence held within the minds of front-line staff (Nutley and Webb, cited in Becker & Bryman, 2004a, p. 40). Indeed it is through their daily practice that policy is constructed (Becker & Bryman, 2004b). Experiences of support professionals offer key perspectives on the complex realities of crisis support. Field research focused on emergency humanitarian arrangements in a large local authority but also drew on semi-structured interviews with workers from outside. In total, 44 interviews were conducted, 17 intra and inter-agency meetings were attended and the researcher had the benefit of numerous informal conversations. Interviews were mostly with local authority field workers of whom 23 were with Crisis Support and/or Emergency Response Group workers. Seven

Police Officers and three voluntary agency representatives were interviewed. Twenty-two of those interviewed had direct involvement in major incidents and 18 were directly involved in one or more of the three case-study incidents. Each transcribed interview was analysed for key issues and themes, which were then coded and compared. Draft data analysis was circulated and feedback incorporated. This was used to minimize errors or misunderstandings and strengthen the credibility of participants' constructions (Cho & Trent, 2006). Draft findings were open for discussion and clarification, and in some cases, where participants were unhappy that their words had not accurately conveyed the intended meaning, wording was amended or occasionally removed. Plans for disaster response, it has been suggested above, are problematic when overly detailed and overly prescriptive. Something very similar could be argued of research. The aim in the research process here was to allow the concerns of both researcher and participants – whether considered in advance or not – to be brought forward. One of the advantages of semi-structured interviews is that issues that might not have been apparent in the research planning stage can be explored. For example, while original schedules were based around key themes derived in literature search, key events and themes raised by interviewees were then incorporated into the research. Research was conceived here as a process within which inflexible adherence pre-defined plans can be problematic. Kidder and Fine (1997, p. 40) note that:

The qualitative stance, being there, off balance, with all pores open, [may] reveal ... patterns that ma[ke] ... original hypotheses look naively clean and simple.

Observed meetings included County Emergency Response Group and Crisis Support meetings, management meetings, incident debriefings and a practitioner conference. Minutes, departmental documentation and some personal correspondence and logs were also drawn upon with permission. Crisis support teams were deployed in three major incidents, one before the research commencing and two during its progress. Outlines of what each incident involved are as follows.²

- Incident 1 involved over 20 fatalities. Around the same number of survivors needed basic physical care and shelter. Potential criminal proceedings against some survivors quickly became an investigative priority. Crisis support staff worked with police and others at a Survivors Reception Centre (SRC). This was quickly relocated to police dormitory facilities. Survivors stayed here for 3 days while the authorities conducted their investigations.
- In Incident 2, there were seven fatalities and no survivors. Body recovery and identification, the immediate challenges for responders, were accomplished within 2 days. CSWs worked jointly with police Family Liaison Officers (FLOs) to support families in their homes and at a Family and Friends Centre (FFC) at a local hotel.
- Incident 3 was a transport incident during which a number of local authorities responded. One person died, but many of the hundred survivors were injured and brought to hospitals within the county. Crisis support staff supported the bereaved family, survivors who were in hospital and their families who converged on the locality and were locally accommodated in hotels at the expense of a corporate Incident Care Team (ICT).

4.2. Limitations of the study

If 'knowledge production happens in the relationship between the knower and the known ... having relationships does not make it possible for us to represent that with which we are related in a perfect way' (Jensen and Lauritsen, 2005, p. 72). On the other hand, 'relationships can be productive ... [and] ... can enable the articulation of new properties of situations and new modes of action' (ibid, p. 72). 'Placing' research, researcher and researched within contexts of power and chains of associations allows knowledge as 'partial connection'. Knowledge may be mediated by complex chains of relationships, but we are able to venture understandings of social realities that account for the research, researched and researcher within such contexts.

This research draws heavily on the experiences of a particular set of workers in a particular locality, reflecting upon particular events and arrangements. It is not claimed that these reflections were value free or 'objective'. Nor can it be assumed that interviewees always tell the researcher 'the truth'. As 'discrete but demanding forays into the lives of strangers', interviews demand 'identity work' (Gerson and Horowitz, cited in Cassell, 2005, p. 176). Interviewers seek to:

... manag[e] impressions of those factors we have some control over – for example, our attitude and responses to the interviewee – and accommodating those we have no control over – for example, our age, gender or ethnicity (Cassell, 2005, p. 175).

Both interviewer and interviewee *perform* in interviews. Of key importance is 'an awareness of the *accounting work* of interview talk, that speech acts ... [are] used to "present the self" in a morally adequate light' (Rapley, 2001, p. 307). Murray (2003) notes the multiple identities, and perceived identities that she had to negotiate during research. Acknowledging the 'frontstage' and 'backstage' elements of performance, she was at different times or even at the same time, a 'spy', a 'shill', a 'go-between' and a 'sociologist'. The researcher in this project, as a former disaster social work practitioner could be seen in a variety of ways: researcher or practitioner, outsider or insider, a support or a threat. The 'truths', then, that were presented to the researcher were inevitably to some extent partial, performative and value based. Although the combination of methods and the use of multiple participants, allowed for cross checking and 'triangulation' of data, it was to be expected that what 'sense'

participants each made of policies, events and responses would differ.

It was also to be expected that data might reflect elements of the broader organizational orientation, views and interests. Where specific incidents are discussed for example, the experiences and perceptions recounted are 'partial' truths of these events. Representatives from other agencies might have had different interpretations of events. In some cases, the general views of other agencies were sought and used. However, it was necessary to retain the focus of the research. It was not possible in the light of available resources, to research the 'full' multi-agency response. Rather, the focus was the Crisis Support Team and its organizational and professional contexts. The Local Authority assumes the lead role in humanitarian aspects of response, although this remains under-researched. The perspectives of its front-line staff are largely absent from disaster literature. This research attempts to consider the implications of the experiences of some of them – partial and local though they may be. As a case study, it gathers qualitative data to capture the specific 'case', rather than using data as a basis to generalize wider empirical conclusions (Hammersley, 2004). Notwithstanding such limitations, wider concerns are raised as potential areas for further research.

5. Findings

5.1. Planning and preparation

Crisis support in the authority was developed through the efforts of key middle ranking managers. From the mid 1990s, they recruited volunteers to a Social Services Emergency Response Group (ERG). Notwithstanding regular and structured training programmes, they were widely regarded at first as a 'Dad's Army' (Crisis Support Worker, 2007).³ Gradually, however, senior management took interest and support increased. Volunteers were expected and – usually – allowed, to attend regular meetings, training, an annual conference and two exercises per year. The ERG, from which Crisis Support Workers (CSWs) were drawn, began, at police request, to deploy volunteer teams at relatively 'small' incidents. Thirty-four incidents elicited ERG responses between 2004 and 2007. They followed the impact of a wide variety of hazards, including structural problems in buildings, police sieges, landslips, floods and fires.

As a core of workers grew increasingly familiar with each other, specific professional roles were de-emphasized. 'What mattered was 'the ability to knock on doors, to get on with anybody ... to communicate ... with people who [we]re extremely distressed' (CSW, 2007). To this extent, while experienced workers were actually very important in responses, 'continuity' with everyday roles was subtly downplayed. Non-social workers, once given the requisite training were, by common account, as valued and as valuable as formally qualified social care professionals. Among social workers, it was a common refrain that crisis work allowed

opportunities to practice skills that 'ordinary' social work no longer did.

The development of the ERG occurred in the context of important developments at a national level. Discussions around the implications of the Clarke Report (2001) were initiated between social services, emergency planning and police. It sought to establish 'joint working' – an ongoing and close partnership with the police. Joint training was developed for CSWs and police FLOs, iterating that police would lead investigation while CSWs would focus on 'the emotional support, practical support side' (Adult Services Manager, 2006). One officer explained:

[Crisis support] work is aimed at helping people cop[e] with what is happening, keeping them informed, keeping them in the picture ... They feel cared for, looked after and it gives them some control, in a small way (Emergency Planning Officer, 2007).

Crisis support focused on the immediate aftermath with longer term recovery regarded as the province of others. Before Incident 1, a number of positive elements were in place:

- ERG members were trained;
- procedures had been established and tested;
- some staff, through regular deployment at minor incidents, had first-hand experience of adapting principles and procedures learned in training to the unpredictable and the unforeseen elements of live incidents;
- Clarke's recommendations, emphasizing the sensitive provision of information, access and respect towards victims were disseminated and understood;
- some progress had been made in joint working with police FLOs.

Some elements of preparedness, however, remained problematic:

- crisis preparation remained an under-recognized adjunct of normal day-to-day work and management support for emergency preparedness remained precarious;
- training and exercising were sometimes hampered by the reluctance of middle and junior managers to sanction attendance;
- Resources were limited;
- ERG 'credibility' had yet to be fully established.

It is to performance in the three major incident case studies that this paper now turns.

5.2. Capacity

While the three case-study incidents posed stiff tests, they lay towards the 'gentler' end of major emergencies. After Incident 1, for example, many victims were from abroad and there were few demands from bereaved friends and families. Demands at the SRC were significant, but not overwhelming. Incident 2 involved fewer fatalities and no survivors. After

Incident 3, uninjured survivors were dealt with in a neighbouring county and there was only one fatality. In no case was there substantial damage to homes or to response capacity.

The volunteer-based model appeared to work well. CSWs 'turned-out' reliably, unpaid, out of hours and not infrequently during annual leave. As crises dissipated, workers promptly returned to normal duties where they caught up on the backlog of everyday work that awaited their return.⁴ However, responses tended to centre around a few key personnel. Experience was the key factor in deciding which volunteers were deployed. In effect, this meant that the same workers tended to be called out. Larger or more complex incidents than these would probably require the deployment of more CSWs and for longer time. Although managers planned to recruit more volunteers to the ERG, this was conditional on the broader embedding of preparation within the organization. Training and exercising require volunteers to be away from their everyday work and in some cases for everyday workloads to reflect this. Moreover, the model in this authority stressed the importance of practice at 'minor emergencies'. It was felt that unless volunteers had regular opportunities to be deployed at 'minor' incidents. The ERG could become vulnerable to de-skilling, inertia, apathy and de-prioritization (Emergency and Crisis Support Managers, 2008). There was already frustration among some volunteers at the infrequency with which they were called upon, and some perceptions that it was 'the same faces' that tended to be deployed (CSWs, 2007). During the research period, management explored the possibility of increasing the opportunities for 'minor' deployments through a partnership with police in response to Road Traffic Collisions. This, it was, hoped would allow opportunities for skills to be renewed and enhanced, for volunteers to feel included and valued and for an important public need to be better addressed (Crisis Support Manager, 2010). As it happened, the planned pilot project was cancelled as funding for this role was allocated to a third-sector agency. Other nascent local authority crisis support teams reported similar experiences (Crisis Support Managers, 2006).

Incidents raised issues around managerial and administrative capacities. Leading the humanitarian response, attending to liaison at Silver Command and directly managing the Crisis Support Team and humanitarian centres proved to be onerous demands to be placed on one manager – a manager who also had a demanding 'day job' to attend to. Administrative resources were sometimes inadequate. After Incident 3, staffing rotas were managed from the spare bedroom of an officer's home. The officer had no relief for 36 hours. There was no facility for a dedicated emergency database and records were entered later on hard copy. Responding peripatetically, workers relied on other agencies for basic facilities – interview space, landline telephones, computers and fax machines. These resources were not always forthcoming. By contrast, the establishment of a hotel-based FFC after Incident 2 gave the team a base, with facilities, where they could meet, share information and plan. Without proper facilities,

CSWs out 'in the field', working with families in their homes, at hospitals, mortuaries or police stations can find themselves isolated and out of touch with the overall picture.

Private and third-sector resources supplemented county resources during incidents, usually to positive effect. Hotels acted as FFCs. Voluntary agencies helped staff centres and assisted in registration, befriending and catering. After Incidents 2 and 3, 'counselling' was offered to some victims by corporate and third-sector stakeholders. There was sometimes a sharp contrast between public and private resources. The ICT involved after Incident 3 had company credit cards and a clear mandate to spend freely. After Incident 1, by contrast, CSWs bought food and basic necessities for survivors out of their own pockets to be repaid later. There were also occasional disputes over 'territory' between CSWs, corporate-funded 'trauma specialists' and faith community representatives. While CSWs were able to refer clients on to private services, after Incident 2 and 3, without a willing corporate donor in Incident 1, the responsibility fell on home local authorities. Here, but in other incidents too, a concern among CSWs was that once they 'exited' from their work with families, there was sometimes no clear successor service to which all victims could be referred. It is also worth noting that potential conflicts of interest may arise where a counselling service is funded or provided by an organization with a particular 'stake' in politics of accountability or blame.

5.3. Continuity

Elements of response that had been rehearsed and practiced in successive 'small' incidents tended to function smoothly. Call-out systems were efficient and communication within Crisis Support was quickly established with mobile phones, the usual medium for information exchange. In general, staff promptly identified and addressed immediate tasks and centres were set up quickly. Teams emphasized pre-established, informal familiarities. Staff took the view that experience gained through regular deployment at 'minor' incidents provided the crucial underpinning for coherent response to major emergencies. Role familiarity, responsibilities and lines of communication were reinforced and renewed through regular 'minor' incident deployments. Considerable trust was evident between managers and field workers on the one hand and between field workers themselves on the other.

Difficulties arose in situations that were discontinuous with previous experience – especially regarding inter-agency relationships. As outlined under section 5.4 below, this could lead to differences in approaches toward victims. After Incident 1, CSWs were deployed not with FLOs, alongside whom they had trained and exercised, but alongside police officers with a straightforward investigative remit. Moreover, although 'the expectation was that the police would run any Survivors' Centre in cases involving possible crime' in this case the police looked to the local authority to take this

responsibility' (Crisis Support Manager, 2007). The outcome was that from the local authority perspective, crisis support priorities were difficult to balance with investigative priorities. Similarly, after Incident 3, difficulties arose when crisis support deployment to local hospitals exposed a weakness in the 'everyday' relationship between health and social services. Access to briefings, information and wards were denied to local authority personnel.

5.4. Flexibility

Considerable autonomy was extended to CSWs. Staff were not rigidly attached to preparation and managers did not 'micro-manage' activities. CSWs were told that senior managers would rely on *them* as the 'experts' (Incident 3 County Debriefing Meeting, 2007). In exercises, workers were encouraged to find imaginative ways of overcoming problems. Operations emphasized informality, flexibility and horizontal information flows. As one participant put it, 'incidents don't read plans' – adapting quickly to circumstances was what mattered (Crisis Support Manager, 2006). Another agreed 'exercises have helped ... but I don't think you could ever prepare for something like [Incident 1]' (Crisis Support Worker, 2007).

After Incidents 1 and 2, managers quickly recognized that some early expectations were misplaced and adjusted responses accordingly. After Incident 1, the FFC was quickly closed down and staff were redeployed to the SRC. The latter, originally established in a council property in a public park could not be shielded from the media and was relocated to the local police headquarters. After Incident 2, the FFC was closed down when it appeared there would be no demand for it, only to be quickly re-opened when bereaved relatives appeared in the car park, having been driven there overnight by police officers from another constabulary. It was a well-judged decision. The FFC became the fulcrum of the response and was a busy, efficiently run hub of activity, providing essential facilities for both staff and bereaved families and friends.

At the field level too, there was evidence of autonomous practice. Allocation of tasks between CSWs and FLOs was not always done 'by the book'. Where pragmatic concerns dictated for example, a CSW notified a family of their relatives' death, disregarding the protocol that this should be a police task. Tasks were divided pragmatically by agreement between the individuals concerned. In Incident 3, it was at field level that CSWs negotiated access to hospital casualty information and integrated the corporate ICT into the response. There was also evidence of adaptive response *between* incidents. Shortcomings in communication between managers in Incident 2, raised in debriefing, informed the response to Incident 3, 2 months later. More fundamentally, difficulties in Incident 1 led directly to intensified joint training and a formal protocol between local authority and police regarding Family Liaison and Crisis Support work, paying dividends in Incident 2.

5.5. Inter-agency issues

The incidents exposed some serious problems in *communication* and *co-ordination*. Beyond these, moreover, were instances of *conflict* running deeper than the contingencies of information flow and management. These were functions of significantly different understandings of the overall 'mission'.

The most significant difficulties were evident in Incident 1. There was little evidence, from a Crisis Support perspective, of 'shared assumptions'. CSWs felt that basic elements of humanitarian response were de-prioritized to investigations into criminal responsibility and immigration status. Some even argued that that 'care' became, effectively, a form of 'detention'. The authority's intention was that the SRC should be secure in the sense of 'keeping people out – but here it meant keeping survivors *in*' (Emergency Planning Management Meeting, 2008).

Working relationships between CSWs and police in Incident 1 were not close. As one CSW (2007) recalled 'we weren't introduced to officers ... We didn't know who was in charge from the police or have the rapport with them that we [did later]'. Priorities were different too. Police suspected, correctly, that some survivors might have committed criminal offences leading to the disaster. From a crisis support point of view, however, this led to the primacy within the overall response, of 'security' concerns. Survivors were very closely managed. CSWs were told that windows should remain closed in case survivors escaped. Cigarettes were given out one at a time and were smoked outside, under police supervision. One CSW (2007) observed 'there was[n't] anywhere to run because they had no proper clothes ... no money [and] there were people on gates.' Information was recorded on custody record sheets, although survivors were not under arrest. In retrospect, CSWs felt strongly that they should have challenged more strongly what they saw as a 'control' focused agenda.

Communication and coordination were far smoother during Incident 2. Bereaved families were not 'suspects' and there were no issues of fundamental contention between agencies. Interaction was respectful and co-operative, building on substantial joint work after Incident 1. Nonetheless, there were some relatively minor problems. For example, CSWs were not allowed into the police station for one 'joint' briefing until it was over. In another instance, CSWs learned of the police decision to name the deceased in a press conference only shortly before it began. Only last minute calls to relatives who had not yet been contacted saved them learning the news via TV. Finally, there were difficulties in co-ordinating times for relatives to view the deceased. At first, relatives were told this would occur within 12 hours. As it happened, some had to wait until the third day after the incident. CSW/FLO teams were left with the task of explaining this to families.

Co-ordination was more problematic after Incident 3. In previous incidents, CSWs main partners were the police. This was a different post-incident environment: the incident

occurred in another authority; there were more victims; more 'sites' at which victims were received; and a more significant role was played by private sector responders. Most crucially, the key relationship that CSWs needed to cultivate to carry out their role was not with the police, but with hospital trusts. Here, however, the lead humanitarian role of the local authority did not appear to be understood and considerable perseverance at 'lower' levels was necessary to establish the most basic information exchange. Extraordinarily, senior managers including the county's Chief Emergency Planning Officer were denied access to the hospital incident control room. They relied on occasional pieces of information from hospital managers inside and co-ordinated their response from a public waiting area outside.

Another unrehearsed inter-agency relationship in Incident 3 was with a corporate Incident Care Team (ICT) that arrived some hours after the incident. The ICT was not aware of the contacts it needed to establish at the onset of the incident. Its 'alternative command structure' had no initial contact with the overall command and ICT workers were deployed with no clear idea of where they would go. Their roles were also unclear to others. Despite this unpromising context, the local authority quickly integrated the ICT into the broader response. The contribution of the latter centred largely on its financial capability. While the CSW was the 'lead' agency, key resources were in the 'give' of the ICT. CSWs found themselves in lengthy negotiation for access to hospitals both for themselves and on behalf of the ICT. The latter, with latitude to spend, was in a position to pay for relatives' transport and accommodation to visit hospitalized survivors. CSWs were in a position, directly or through liaison, to access social services resources on the basis of needs assessment. Hospitals, however, would not at first divulge casualty lists or let support workers see patients.⁵ While one hospital allowed CSW staff to visit patients after several hours, the second hospital did not permit this for 2 days after the incident. The reason given was that to do so would contravene data protection legislation. Information sharing in general was poor. Even some weeks after the incident, events remained unclear even to local authority senior management. Ensuring a cohesive and 'integrated response this seems to confirm depends largely on the quality of pre-existing relationships with agencies brought together by events.

6. Conclusion: issues for future research

It is often upon their treatment in the first hours and days of emergency that victims come to reflect most angrily. Especially where fatality has occurred, friends and families are entitled to be treated with respect (Coleman et al., 1990; Davis & Scraton, 1999). Clarke (2001, p. 114) suggested four general principles to 'be kept in mind' throughout the identification process: provision of accurate and honest information; respect for both the deceased and the bereaved; 'a sympathetic and caring approach' and 'the avoidance of

mistaken information'. The removal of body parts or the denial of requests to view the deceased, he concluded, need to be justified by 'necessity', in order not to violate article 8 of the European Convention of Human Rights (protecting private and family life).

In the context of this, and other detailed attention to the treatment of bereaved people, it is perhaps surprising that local authority-led major incident 'crisis support' teams have received so little discussion in guidance or professional literatures. It appears simply to be assumed that local authorities will have ready access to, and will be able immediately to deploy, suitably qualified, experienced and skilled workers in the event of disaster. Given that such deployments have traditionally comprised of social workers, the implications of developing critiques of the state of modern social work require proper consideration. 'Social work as we knew it', one crisis manager (2010) stated, 'has ceased to exist'. It is a comment that reflects the literature and is representative of the views of most social work practitioners interviewed in this project.

ERG managers in this local authority took the view that recruitment should not be restricted to social workers and that competence was best assured not only through training and exercising but also *through regular deployment at 'minor' incidents*. They sought to establish and develop a pool of volunteer workers capable of immediate major emergency response. These findings suggest that, although it relies heavily on flexibility, goodwill and unremunerated commitment, this, with some important caveats is a viable model. In each incident, the local authority was able to deploy CSWs who had clear understandings of their roles and especially in the latter two incidents, experience of operating in emergency situations. They knew each other, were able to make judgements within a solid understanding of the broader responses and their places within them, and after Incident 1, they became increasingly confident in asserting humanitarian priorities in inter-agency work.

The caveats attached to this picture are, however, significant. In terms of capacity, incidents stretched crisis support. In particular, they placed heavy demands on managers. Larger, longer or more complex engagement would have required significant additional redeployments of staff from their 'normal' tasks. Should incidents occur when key managers are unavailable, workers were not confident that other managers, with little or no involvement in the ERG would be well placed to direct operations. This reflected a broader reality, that notwithstanding its recruitment of non-social workers to the ERG, major incident responses continued to rely heavily upon key individuals. Most, but not all, of them were qualified social workers.⁶

The most significant issues facing crisis support concern its place within wider multi-agency response. The role of crisis support potentially overlaps with those of some other responders. Experience in Incidents 1 and 3 confirm that working together in the immediate aftermath of disaster continues to seriously challenge organizations. Crisis

support teams found co-operative work difficult with, at different times, police, hospitals, private trauma counselling companies and corporate customer care. This was not always manifested overtly. In contrast, perhaps the most important differences in perspective, around the accommodation of survivors after Incident 1, were largely suppressed through local authority deference to police leadership. Lessons learned here went beyond those expressed in formal review. There were strong feelings among CSWs that they had 'let survivors down' by too easily acquiescing to the priorities of investigative agencies. Several workers and managers made it clear that their intention was that this should not happen again. Incidents 2 and 3, by contrast, saw CSWs operating more assertively, and in the former case, in very close co-operation with police. However, the latter incident highlighted the problems that arise where there has been little sustained contact between agencies before them coming together in major emergencies. In this instance, this was reflected in almost total unfamiliarity between local authority and hospitals in the first days after the incident. In addition, the incident demonstrated that if the difficulty of maintaining relationships between category 1 responders is onerous, there are now new potential actors on the emergency scene. How national level corporate responders are to be integrated into response may present particular difficulties given that it is not clear to what extent they will be able to participate in local planning, training and exercising before major emergencies strike.

Crisis support work – although it has gone under different names – has been a fixture of major emergencies in the United Kingdom since the mid 1980s. Grounded in and growing out of local authority social work responses, it is overdue for review. Whether local authorities should continue to carry the primary responsibility for humanitarian co-ordination and intervention in the crucial first days after disaster is an open question. If the answer is 'yes', there are clearly issues that need to be addressed with some urgency: capacity, both for preparation and response; continuity (and discontinuity) with non-emergency work; flexibility within large bureaucracies; and the realities of co-operation and conflict in the fraught conditions of emergency.

Notes

1. As part of a PhD, the research carried the necessary institutional ethical approvals. Research participants were anonymized.
2. Agreement with the local authority dictated that it should not be identified in subsequent publications and to this end the full details of the incidents are not recounted here.
3. *Dad's Army* refers to a popular BBC TV comedy series, which ran from 1968 to 1977. It centred around the antics of a company of Home Guard volunteers in the Second World War. The reference here may be taken to refer – not altogether without affection or appreciation – to the enthusiastic and well-intentioned, but clearly 'amateur' character of the mainly elderly volunteers' efforts.
4. There were some reported instances where non-emergency managers and workers complained that 'everyday' tasks had to be re-allocated to accommodate a staff member's participation in the ERG.
5. Some patients were angry about this when they found out later that support services had been trying to see them. This was particularly the case where families lived at a distance or had circumstances that made it difficult to visit.
6. While these workers were often critical and pessimistic towards contemporary state social work, they could draw upon many years of relevant experience. Without them, it is far from clear that responses would have been as effective as they were. Whether, as these workers move on, or into retirement, they will be replaced by younger social workers with equivalent skills remains to be seen.

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