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article

The Manchester Attack Support Group Programme: modelling a psychosocial response to collective trauma

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This article discusses a support group programme initiated in response to the Manchester Arena attack in 2017 as an example of a psychosocial approach to post-disaster support. Its purpose is to highlight how a bespoke psychosocial peer-based initiative can complement and enhance mental health responses following collective trauma events. It gives an overview of psychosocial approaches to disaster aftercare and presents survey-based and other feedback gathered throughout the life of the programme. The results suggest that facilitated peer support has enabled bereaved people, survivors and responders to share and make sense of their experiences, benefit from mutual support and enhance their coping and resilience. A multidimensional psychosocial approach to peer support has culminated in the development of a self-sustaining peer support network. The case study builds on the evidence base supporting the value of psychosocial approaches as an important complement to clinically focused mental health interventions following a collective trauma event.

Key words psychosocial support • collective trauma • disaster • peer support • emergency planning

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Introduction

Acts of terrorism can have profound psychosocial impacts on individuals and communities. As collective trauma events, they result in 'a blow to the basic tissues of social life that damages the bonds between people and impairs the prevailing sense of community' (Brady et al, 2018). Addressing the needs of those affected by terrorism and enabling their access to psychosocial support have been identified as a fundamental human right (UNODC, 2015). International and UK guidelines recommend promoting peer-based connectedness and psychosocial support as complementary to individual interventions. They build on evidence which shows that boosting and protecting social support can increase an individual's capacity to deal with a potentially traumatic event (Norris and Stevens, 2007). In particular, research has highlighted that peer support groups in recovery after trauma contribute

positively to sense-making processes, narrative co-creation and identity construction (Van de Ven, 2020). However, relatively few examples of psychosocial peer support programmes feature in the peer-reviewed literature.

Recent research by Rew (2021) with more than 80 terrorism survivors, including from the 2017 Manchester Arena attack, has highlighted an overwhelming preference by those affected by terrorism to seek support through peers who have experienced the same event as opposed to seeking support through professional, established victim support organisations. Her study found clear evidence that individuals felt that formal support often lacked personalisation in terms of the support offered. Respondents felt they were just one of many individuals looking for support and that a standard set programme was all that could be offered (Rew, 2021: 72).

This article describes the rationale for and development of a peer support group programme devised as a psychosocial intervention to complement and enhance mental health interventions following collective trauma. Building on theoretical frameworks of trauma psychology and peer support, the role of peers in psychosocial support is presented with particular reference to forms of peer support group following UK disasters. International psychosocial recommendations following major emergencies are then considered, followed by UK guidelines on psychosocial care after major incidents. Illustrating the application of these recommendations in practice, the Manchester Attack Support Group Programme (MASGP) is then described, followed by a brief evaluation of and feedback about the programme. Finally, the article considers future directions and how this model of psychosocial support could be applied after other major incidents.

Collective trauma, peer support and psychosocial studies

'Collective trauma' is a social and psychological concept that emerges when individual traumatic experiences massify (many individuals are traumatised), aggregate (through shared and relatable experience) and, as such, become part of the collective psyche (Cherapanov, 2020). Disciplines such as the social psychology of trauma offer deeper insights into the experiences of, and responses to, trauma by highlighting the interconnectedness of the clinical and social domains in trauma studies. Studies have shown that shared trauma history can become a unifying experience by establishing a common frame of reference where victims can relate to and support each other and share information and resources.

Research in clinical psychology and social psychiatry has also highlighted the importance of social factors and co-created identities for outcomes following trauma. Muldoon et al (2019) suggest that the strong social identities that result from defining oneself in terms of a larger collective can be an important source of strength, and that where old or new positive identities are reinvigorated or extend the self, this can be a basis for post-traumatic growth.

This article reflects one of the guiding principles and fundamental assumptions within these approaches and in psychosocial studies, namely that subjective experience is interwoven with social life. It builds on learning that integrates the individual and collective dimensions of trauma and reviews the value and importance of peer support within this context. While peer support is part of a 'personal journey' (Walker and Peterson, 2021: 224), it also operates within a complex system comprising the individual, the community and the wider social structure. An exploration of peer support in this context is, it is suggested, relevant to both academics and policy

makers interested in the links between the psyche and the social and in psychosocial responses to future collective tragedy. Given the proliferation of collective trauma and soothsaying predictions around more and worse disasters in future (Quarantelli, 1991), it is also timely.

The role of peers in psychosocial support

The concept of 'peer support' has a rich history and while 'it's a safe and happy assumption that as long as humanity has existed, human beings have helped each other out' (Shaw, 2014: 6), peer support has evolved as a group/community intervention in response to and as a complement to individual models of treatment or therapy. While there are many different definitions and meanings of the term 'peer support', it is inherently a psychosocial concept within mental health, reflecting the interaction between individual and social experiences, thought and behaviour. The group context is significant here because peer support is about sharing emotions and experiences through story exchange with people who have endured a similar experience. It takes those similar experiences as a starting point for creating empathic understanding and mutual support and is based on principles such as respect, trust, shared responsibilities and mutual support (Van de Ven, 2020).

In their general literature review of peer support and peer support services, Shalaby and Agyapong (2020) highlight how self-help groups – as the oldest and most pervasive types of peer support – reach back beyond the earliest asylums, psychiatric models around madness and diagnostic criteria. It was in response to these kinds of 'treatment' settings that the Alleged Lunatic Friends' Society – the earliest peer support group in mental health – was founded in England in the middle of the 19th century (Hervey, 1986). A broader definition such as Penney's (2018: 1) is useful here, defining a *peer* as 'an equal, someone with whom one shares demographic or social similarities', and *support* as expressing 'the kind of deeply felt empathy, encouragement, and assistance that people with shared experiences can offer one another within a reciprocal relationship'. Penney also refers to peer support as an organised strategy for giving and receiving help, which can be understood as an extension of the natural human tendency to respond compassionately to shared difficulty.

Mead et al (2001: 6–7) emphasise the importance of this peer dimension being 'not based on psychiatric models and diagnostic criteria'. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain: 'When people find affiliation with others they feel are "like" them, they feel a connection.' They explain the advantage of this peer connection over other forms of intervention or approach: This affiliation 'is a deep, holistic understanding based on mutual experience where people are able to "be" with each other without the constraints of traditional (expert/patient) relationships'.

Given the rapid growth of peer support and the need to ensure it grows with integrity, an international consortium of peer leaders has produced a charter on the guiding values, principles and practices of peer support (Stratford et al, 2017). The peer leaders highlight the importance of lived experience and the wisdom accrued by this as channelled through peer support and the value of sharing personal experiences as a fundamental element. Quoting Beales and Wilson (2014: 5), they state: 'The rule of thumb should always be that if it is a role that you could do without lived experience of mental health issues, it cannot be peer support' (Stratford et al, 2017: 2).

Given these wide-ranging approaches and applications, researchers stress the importance of being clear and maintaining integrity (Stratford et al, 2017: 2) when defining the meaning and nature of 'peer support'. Penney (2018: 1) agrees, commenting on the fact that there is no agreed-upon definition of the term. However, by examining the history of peer support, reviewers have differentiated between two major categories that are often conflated in the literature: *peer-developed or informal peer support*; and formal or *intentional peer support*, which evolved later. Penney (2018), for example, describes how in the United States (US), peer-developed peer support first originated in informal self-help and consciousness-raising groups. Organised in the 1970s by the ex-psychiatric patients' movement, these grassroots, relatively unstructured forms of self-help involved equitable horizontal relationships based on the principles of empowerment, self-healing, community and voluntariness. In the 1990s, these informal forms of self-help evolved into more structured, independent, peer-run, non-profit organisations, generally with some government funding.

More formalised peer support approaches include intentional peer support. This involves a more theoretically based, manualised approach that recognises the central role that trauma plays in the experience, diagnosis and treatment of people and highlights the importance of a trauma-informed approach to peer support (Mead, 2014). As it has developed, formal or intentional peer support has diverged from peer-developed peer support by including more paraprofessional and hierarchical roles, often in traditional mental health settings and programmes (Faulkner and Basset, 2012). The rapid growth of peer support services, peer support worker roles and terms such as 'peer mentor' and 'peer specialist' has somewhat added to the confusion around the meaning and application of peer support, as there is now much variation in definitions, job titles and service roles (Penney, 2018: 3).

Penney (2018: 8) states that it is perhaps not surprising that much of the literature reviewed conflates a variety of peer-delivered services with 'peer support' because peer-developed peer support approaches are not generally available in clinical settings. This is significant because it ties in with the kinds of evaluation measures that focus more on individualistic and clinical outcomes than on other variables. Penney looks forward to the possibility of further research looking at the effects of peer-developed approaches to peer support implemented in peer-run programmes, using non-clinical outcome measures that correspond to the principles and practices of peer-developed peer support (2018: 9). The value of this, she suggests, includes promoting the expansion of services that are congruent with the original, peer-developed meaning of peer support (2018: 9).

Van de Ven (2020) responds to Penney's call for research focusing on non-clinical outcomes and further addresses the limitations of peer support studies reflecting strong positivist clinical measures. She highlights how rather abstract, instrumental and quantitative approaches to peer support within medicine and mental health care research tend to measure its 'effectiveness' in terms of outcome variables such as better health and wellbeing at the expense of doing justice to the collective experience of narrating and connecting. Instead, and in line with the current stream of and demand for empirical research in narrative victimology and criminology, she uses a narrative approach to explore how peer support in the aftermath of trauma functions as a vehicle for identity change and reconstruction and identifies how processes of sense making and identity construction unfold over time. Using observational methods, she found that over the course of peer support meetings, processes of confirmation and normalisation

contribute to the sense making of a traumatic experience and to the construction of post-trauma identity. Such approaches to peer support show how, through listening and talking to people who have endured a similar traumatic experience, people are able to both gain self-awareness and help others. 'Through this cocreation of a recovery narrative, an identity shift takes place' (Van deVen, 2020: 1835). In line with other studies identifying phases of growth within peer support settings, Van de Ven thus highlights the importance of the peer support setting in particular as an arena for the creation of a recovery narrative and as a self-help strategy in the recovery process.

Peer support following collective trauma

The impetus to connect with others for peer support is also a common instinct and response following collective tragedy. Across the world the multitude of groups formed by bereaved people and survivors after particular disasters exemplifies this. Eyre and Dix (2014) refer to the sense of a 'common bond' among those affected by disaster that explains this. The acknowledgement and recognition of common experience enables group members to 'open up completely, without fear of judgment, about the most difficult aspects of their experience' (2014: 19).

Forms and functions of peer support in the context of collective trauma events have been outlined by Eyre (2019) within the landscape of post-disaster psychosocial support. She describes how, across time and culture, both informal and more organised formal peer support has helped individuals and communities to process traumatic grief and complex loss in the aftermath of mass fatality incidents. An early example was after the 1942 Cocoanut Grove fire in the US. Lindemann's study of bereaved survivors (1994) highlighted the importance in people's recovery of reconstructing social ties and connecting with others through the formation of new relationships. His work was a seminal contribution to understanding grief and trauma recovery in a psychosocial context (Rosenfeld, 2018). A further example of peer support came after the Aberfan disaster in Wales in 1966 in which 144 people, including 116 children, were tragically killed. A group of young mothers from the village spontaneously came together to form a support group. Connected by their mutual experience and understanding of collective loss, they met up a few months after the disaster to provide friendship and mutual support. Sixty years later, they continued to meet for weekly tea-and-chat gatherings (Hill, 2016).

The advantage of these informal initiatives with their inherent validation and empathy over 'professional' interventions at the time is highlighted by Aberfan survivor, Gaynor Madgwick. She describes her interaction as an eight-year-old with psychiatrists after the disaster as both terrifying and stigmatising. The medical tests she and other young survivors endured for identifying mental impact and compensation assessment purposes (BBC News, 2021) were experienced as 'space tests with wires jelled to my head with metal clips … No one can imagine how I was feeling' (Madgwick, 1996: 45–6). Such interventions reinforced stigma and notions of madness. Even well after this period (and some might even argue still today), elements of the mental health profession and post-disaster psychological intervention were dominated by assumptions of disaster victims as being 'mad, bad or sad' (Eyre and Dix, 2014).

During the 1980s – a decade of disasters in the UK – many independent peer support groups were initiated by and for those directly affected by particular incidents. Their membership consisted of bereaved family members or survivors or sometimes a

mixture of both. In the absence of coordination and central information points, such as those now provided through police family liaison officers and formal humanitarian assistance arrangements, such groups emerged to provide mutual support, share information and activate collectively for the pursuit of common goals such as answers, the prevention of similar incidents and/or legal outcomes (Spooner, 1990). Examples included the King's Cross Families' Action Group (following the Underground fire in 1987); the Herald Families' Association (following the sinking of the Herald of Free Enterprise off Zeebrugge); UK Families Flight 103 (after the 1988 Lockerbie Disaster); the Hillsborough Family Support Group (for bereaved families from the Hillsborough Stadium disaster in 1989); and the Marchioness Action Group (after the 1989 sinking of the Marchioness pleasure boat on the River Thames).

Such groups were similar in form and function to the kinds of informal, peer-developed peer support initiatives described by Penney et al, noted earlier in this article, combining informal self-help with consciousness-raising in reaction to negative experiences of the authorities' responses and a lack of accountability for predictable and preventable tragedy. In addition to activism around particular incidents (such as campaigning for better ferry, airline or riverboat safety), group members provided the kind of mutual support and understanding often unavailable from family members, friends and wider society and a haven from the ostracism frequently associated with being disaster victims.

In 1991, bereaved people and survivors from a number of these disasters, along with representative family support groups, came together to form the umbrella organisation Disaster Action – an independent, peer-led association (Eyre and Dix, 2014). Forged in the pursuit of three aims – accountability, support and prevention – Disaster Action combined mutual understanding and peer support with campaigning, education and advisory services. It arose as a model example of a peer-run organisation with a clear vision, constitution, organisational structure and executive roles. Disaster Action's vision, principles and practices embody the kind of more formal, intentional peer support approach expounded by Penney et al, with peers naturally coming to understand their problems in the larger social and political context from which they emerge, rather than pathologising themselves (Mead et al, 2001: 8).

Driven by a strong sense of collective conviction and outward-facing focus ('we don't want anyone else to go through what we've been through'[1]), the group was instrumental in helping achieve legislative change around corporate responsibility and accountability in the UK and enhancements in emergency procedures and psychosocial support. Its members continue to deliver peer mentorship and support, bringing together bereaved people and survivors from disasters for mutual support and helping others establish their own independent associations. This has included the UK Bali Bombings Victims' Group, the September 11 UK Families' Support Group and Tsunami Support UK (Eyre and Dix, 2014).

Such examples demonstrate the value of a participatory approach and an appreciation that even when at risk, people are not passive victims. Rather, affected individuals and groups are recognised as having existing assets or resources, indicating inherent personal and community resilience and social capital. This reflects the kind of wellness model within the wider mental health literature – promoting the positive aspects of people and their ability to function effectively and supportively, in contrast to an illness model, which places more emphasis on people's symptoms and problems (Repper and Carter, 2011: 394).

Post-disaster facilitated talking groups

A third form of peer support helping to provide relief following collective trauma events is located in facilitated talking groups. In many high-risk settings such as the emergency services and the military, peer support programmes have emerged as standard practice for supporting staff routinely exposed to potentially traumatic events (Creamer et al, 2012). Examples include Critical Incident Stress Management (CISM), Trauma Risk Management (TRiM) and the Emergency Services Trauma Intervention Programme (ESTIP) (Oscar Kilo, 2021).

In these models, peer supporters play a central role in both individual and group interventions by offering personnel a chance to share their experiences with associates who may be in the best position to understand these experiences. 'It's much easier to talk to your colleagues who understand the nature of the job than it is to a counsellor or other mental health specialist who is a stranger' (King's College London, 2022). The advantages of using peer practitioners rather than professionals with a health or welfare background include reducing the stigma around traumatic stress and its associated problems. It promotes the sense that personnel are not alone and encourages the idea that there is no shame in seeking help – both contribute significantly to bringing about changes in organisational culture (Milliard, 2020).

It is generally agreed that the goals of peer support in these settings do not relate solely to helping individuals recover from a traumatic or highly stressful incident; rather, peer support functions to help maintain and promote psychological and physical health and wellbeing more broadly (Creamer et al, 2012). Research into burnout and staff retention among health professionals has also identified the importance of peer support.

The notion of facilitated talking groups as a vehicle for peer understanding and support also embraces non-professionals directly affected by disaster, namely bereaved people and survivors. Such talking groups have been facilitated since the Hillsborough disaster (1989), the Oklahoma City bombings (1995), the September 11 attacks in New York (2001) and the Oslo and Utøya attacks in Norway (2011).

Post-disaster psychosocial support programmes are not limited to addressing needs after acts of terrorism or socio-technical incidents. Despite different causation, the psychosocial impacts and needs generated by 'natural' disasters as collective trauma events are often similar Disasters.org, 2015. Examples where facilitated talking groups have enabled peer support have also included the British Red Cross Tsunami Support Network (TSN, 2005–06), established in the UK by the British Red Cross in response to the 2004 Indian Ocean Earthquake and Tsunami, and the Christchurch earthquake bereaved support programme in New Zealand (Wills, 2017).

The TSN was founded on the principle of providing facilitated talking support groups for UK-based bereaved people and survivors while at the same time coordinating collective family meetings and working towards the establishment of an independent, self-determining association. Drawing on peer mentoring and advice from Disaster Action, this was achieved with the founding of Tsunami Support UK (TSUK) as an independent, mutual support group by and for the bereaved and survivors (Eyre, 2017). An independent review of the response to the Indian Ocean Tsunami concluded that the TSN was one of the most highly rated and effective services provided after the disaster, fulfilling both support and advocacy roles. They

recommended it as a good model for future use, particularly with reference to the way the Network moved quickly away from methods based on "experts talking at" those affected, towards approaches that allowed people real participation and ownership in the Network's activities (NAO, 2006: 14)

The role of hybrid professionals in post-disaster peer support

Watkins (2017) argues that peer-based support groups, where appropriately organised and carefully facilitated, offer an important and effective form of psychosocial intervention after disaster. She highlights three different approaches to the initiation and facilitation of peer support in this context, namely:

- 'Vertical groups' (providing support for) – initiated and facilitated by professional service providers. Group leaders facilitate these on the basis of their professional expertise versus direct disaster experience.
- 'Horizontal groups' (providing support by) – initiated by and for those directly affected, with participation and belonging based on direct experience of the same disaster.
- 'Multidimensional groups' (providing support with) – initiated and facilitated by those with previous personal experience of disaster for those with newer experience. Although having a rarer combination of skills and experience, facilitators' credentials may be a mix of both direct personal experience and professional experience in providing disaster-related support.

It is significant that key role-holders in the foundation and delivery of programmes such as Voices (2021), the TSN and support group programmes following the Christchurch earthquake, Paris attacks and Manchester Arena bombing were all hybrid professionals in terms of having both personal and professional experience in collective trauma. In all of these programmes, principal managerial and operational personnel included individuals with both lived experience of disaster as directly bereaved people or survivors and a record of professional qualification and experience in trauma/disaster. On the one hand, they meet the standards for 'peer supporters' as identified by Creamer et al (2012) – having lived experience and undergone organisational application and assessment processes as part of their recruitment and selection. On the other hand, their expertise includes qualification and experience in addressing collective trauma, which extends beyond single programmes and includes professional accreditation in fields such as counselling, psychotherapy, psychology or sociology. Their professional knowledge and practice enable the introduction into the groupwork of tested methodologies and therapeutically based approaches for working in post-trauma settings (Watkins and Lewis, 2022). In this sense they are distinct from being paraprofessionals or other types of peer service workers who may lead or facilitate peer groups as individuals with lived experience but who are not licensed to practise as a professional or do not have additional formally recognised qualifications and experience in trauma and disaster. Where hybrid professionals play a key role in designing the philosophy, rationale and frontline delivery of peer support programmes, the result is a blended combination of peer-developed, peer-run and trauma-informed approaches.

Mental health and psychosocial support in emergencies: international recommendations

International guidelines for organising support following major emergencies recognise the strong interaction between psychological and social factors and recommend the provision of a range of psychosocial responses to disaster, including peer connectedness and peer support. Indeed the composite term 'mental health and psychosocial support' (MHPSS) has become the consensus term for any type of local or outside support aiming to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder (IASC, 2007). Guidance documents have thus evolved to include a more coordinated approach, which interweaves psychosocial considerations into mental health standards and key actions (IASC, 2007; Sphere Association, 2018). They also focus on active stakeholder engagement and participation, integrated support systems and multi-layered support.

By way of example, a stepped care model of mental health support and programmes, from general psychoeducation to longer-term specialist pathways, is reinforced in guidance produced by NATO (2008) and more recently in international best practice guidelines produced by the Australian Red Cross in relation to collective trauma events (Brady et al, 2018).

In 2013, an international symposium on traumatic stress identified common lessons from international researchers and clinicians involved in psychosocial responses to disaster. These included the need to emphasise the importance of providing multidimensional psychosocial care and recognition of social dimensions and sources of resilience, two fundamental principles underpinning the peer support model discussed in this article.

UK guidance and shortfalls in psychosocial aftercare

Public Health England's 2020–25 strategy identifies effective responses to major incidents as a key priority (PHE, 2019). A framework for implementing a stepped model of care is provided by NHS guidance (PHE, 2009), which acknowledges that services should be provided both by the health care sector and also colleagues involved in humanitarian assistance, social care and the third sector (PHE, 2009: 8).

In relation to terrorism, evidence highlights the importance of addressing the significant impact of psychological trauma. Hind et al (2021) report that those present at a terrorist attack have a 33–39 per cent chance of developing post-traumatic stress disorder (PTSD) within one year, with 17–29 per cent of those close to the injured, 5–6 per cent of emergency and recovery workers and 4 per cent of local communities similarly affected. Children are particularly vulnerable (Hind et al, 2021: 2). After both the 2005 London bombings and the 2011 attacks in Norway (Reifels et al, 2013), screenings quantified significant longer-term impacts (including PTSD, complicated grief and general psychological distress) and the need for support one and a half and two years after the attacks, respectively.

Guidelines from the National Institute for Care and Excellence (NICE) on PTSD recommend access to specialist mental health, evidence-based assessment and treatment services. This may include interventions such as trauma-focused cognitive-behavioural therapy (TF-CBT); eye movement desensitisation and reprocessing therapy (EMDR); or pharmacotherapy for a minority of individuals who go on to develop severe

mental health issues (NICE, 2018). NICE's latest update also recommends helping people with PTSD to access peer support if they want to and could benefit from it – facilitated by people with mental health training and supervision, and delivered in a way that reduces the risk of exacerbating symptoms, provides information and helps people to access services.

However, UK studies with those directly affected by terrorist attacks highlight shortfalls in the existing systems of support.[2] In 2016, Barker and Dinisman (2016: 8) reported that for some survivors and bereaved family members, waiting times for National Health Service (NHS) counselling or therapy services felt too long and that treatment for PTSD was not offered by all NHS mental health trusts in England. They also reported that accessing peer support groups, particularly locally, was similarly problematic for many of those affected by a terrorist attack, despite it being something they identified as crucial to their ability to cope with what they had experienced. The authors recommended immediate work to address this, including mapping and agreeing pathways of support across victim services (Barker and Dinisman, 2016: 9).

One of the main barriers to terrorism survivors accessing formal support remains the lack of joint working between agencies, resulting in delayed treatment times (Matthews-King, 2019; Rew, 2021: 75). Given this, it is unsurprising that many individuals affected by the Manchester Arena attack in 2017 instinctively reached out through the internet for information and connection with others. Just as for those affected by earlier terrorist attacks in Paris in 2015 and Tunisia in 2015, sharing experiences with fellow survivors felt preferable and more comfortable than speaking with family, friends, medical professionals and untrained victim support workers (Rew, 2021: 72).

The Manchester Attack Support Group Programme (MASGP)

The creation of the Manchester Attack Support Group Programme (MASGP) was informed by an appreciation that a proportion of those directly affected by collective trauma events are likely to have continuing need in the medium to longer term, that social support is the single most powerful protective factor for trauma victim connectedness and that promoting connections through support groups can positively influence post-disaster mental health and psychosocial recovery (Norris and Stevens, 2007). In line with guidance and recommendations, the programme leaders designed a model approach to complement and extend the existing range of mental health services within a broader framework of longer-term psychosocial care.[3]

The aim of the programme was to provide a bespoke, incident-specific network of peer support groups for individuals affected by the Arena attack. The intention was to enable participants to meet with others who had been through a similar experience, to counter a sense of isolation through connectedness, and to share information and resources to enhance coping, resilience and a sense of efficacy. The aspiration was also to offer the group sessions in locations convenient to where attendees lived, as far as logistically possible, so as to avoid them having to travel, for example, back to Manchester. Programme leaders also felt – and this has been borne out through the delivery process – that appropriately facilitated peer support could complement and even increase individuals' take-up of specialist psychological therapy where needed.

The programme was informed by a number of psychosocially based therapeutic and mental health approaches, including those embracing empirically supported intervention principles following mass trauma (Hobfoll et al, 2007), a phased approach

to trauma recovery (Herman, 1997), peer-based mutual support and the potential for post-traumatic growth at individual and collective levels (Tedeschi, 2020). This resulted in a psychosocial model of both individual and collective trauma transformation and focused on multiple sources of support: vertical (formally organised and facilitated programme leadership informed by lived experience); horizontal (peer-based mutual support and informal, peer-driven connections); and peer-driven (peer mentorship informed by professional skills and experience). In practice, this was reflected in a holistic approach, which integrated members' personal and shared experiences of resilience and coping within the psychosocial reality of ongoing events such as the continuing public inquiry, anniversaries, memorialisation and media interest.

Flexibility was designed into the initial scoping, which tentatively projected six regional groups with up to ten participants, each run by paired facilitators on a six-weekly basis over the course of two years. With the support of multi-agency partners, the initial outreach resulted in more than 100 people expressing interest and the establishment within a few months of 11 groups. With further newly emerging need, group mergers and closures, the number and location of groups varied over the life of the programme. It rose at one point to 15 in response to a further phase of outreach but overall the average number of regional groups was nine. By October 2020, 175 regional group sessions and several all-group events had been delivered, including the successful transition to Zoom-based meetings during the COVID-19 pandemic lockdown.

The role and skills of facilitators

The group facilitators were recruited as a network of professionals with advanced understanding of the context of disaster and experience of working with complex loss and trauma. Recruitment was subject to qualification to postgraduate-level diploma and accreditation by relevant professional bodies as well as group facilitation experience. The facilitators and supervisors had complementary skillsets in areas such as:

- managing grief, loss and trauma;
- running peer support groups, including disaster- and terrorism-specific groups;
- providing therapy to individuals affected by complex trauma and disaster;
- working with victims of crime and homicide; and
- treating child bereavement and trauma.

These facilitators played a crucial role in delivering the regional support group sessions. An orientation programme, regular debriefs, reviews and ongoing development meetings achieved collaborative learning by sharing experiences and feedback throughout the evolution of the programme. The unique background of each facilitator and the diverse nature of the groups further enhanced this. In the support group setting, their skills lay in their ability to oscillate between creating and maintaining environments of therapeutic safety, normalisation and coping at the same time as functioning as 'guides from the side', enabling most of the agenda, discussion and peer validation to be generated and shared among group members. In this way, mutual understanding, authentic empathy and reciprocity took centre stage in an environment of shared identity based on members' lived experience of the attack and its aftermath (Watkins and Lewis, 2022).

Transition to an independent peer network

As the group sessions continued, their facilitated focus expanded beyond individual and internal group experiences to embrace a more collective and outward focus. At first, group structures and membership had focused on homogeneity – building a sense of safety through mutual understanding and a common identity (for example as bereaved people or as responders). Later, a gentle therapeutic focus shifted towards enabling further exploration of differences, such as varying experiences of the disaster, loss and mourning. Later the groups' focus progressed towards more independent and collective meaning making, adjusting to the external world, future orientations and agency. Overlapping this and as part of the programme's pre-designed exit strategy was a transition towards connections between the constituent groups, first through mergers and cross-group meetings and later through the introduction of all-group events as the small group sessions came to a managed end.

These latter phases coincided with the onset of the pandemic in 2020 and during lockdown the programme successfully migrated online. The continuing all-group events included workshops, anniversary planning and opportunities to meet and learn from the lived experience of others who had been through different disasters such as the Paris attacks and the Norway shootings.

A key achievement during this phase of the programme was the establishment by cross-group participants of a new independent, sustainable, self-managed peer support network. This was inspired in part by learning from programme leaders about how peer-initiated and peer-led associations had successfully evolved from the grass roots. The Manchester Arena Support Network now functions as an independent peer network run by and for those affected by the Arena attack, providing connection, mutual support and friendship. It is managed by a committee of its members and runs various WhatsApp, Twitter and Facebook groups. Within weeks of its formation, the network had attracted 40 members and more than 100 followers on Twitter. The MASGP programme leaders continue to provide mentorship for peer leaders of the committee on practical and emotional support matters based on their own experiences of peer participation and leadership in incident-specific support groups.

Programme evaluation: methods

Various methods were used to evaluate the programme and its impact on participants. Primary data were formally collected from group members using an online survey and event-based evaluation forms. The survey was administered at three stages of the programme and designed to gather feedback on participants' aims and wishes and experiences of the programme at the start (Stage 1), after six sessions (Stage 2) and at the conclusion of the local group sessions (Stage 3). The questions were aligned to the purpose of the groups, which built on Hobfoll et al's (2007) key intervention principles following mass trauma events and the promotion of calmness, safety, connectedness, efficacy and hope.

In addition, informal and formative feedback was gathered from facilitators through regular debriefs (after each group session), supervision sessions and facilitator review and learning workshops. In line with the philosophy of a flexible, responsive and participative approach, this information was used to hone elements of the programme as it proceeded and adapt it to users' needs and wishes where possible. One example

of this was a request from group members for young people's groups, in response to which a number of such sessions were introduced. Another was a workshop series designed with participants around planning, producing and delivering content for an anniversary event. Feedback was also gathered after the two all-group events and via online evaluation forms from workshops in the final phase of the programme.

Group attendees contributing to the evaluation process – or programme members – were all directly affected by the Arena attack. They were bereaved individuals and/or survivors (some seriously physically injured) and responders, including those non-trained or 'zero responders' who spontaneously joined the emergency response at the Arena. The location of the regional groups reflected the areas from where many people travelled for the concert – the North West, North East and East of England and Central Scotland – and there was a telephone-based group. The programme was primarily aimed at adults but also delivered a few young people's sessions. Most of the regular local group members (three quarters) were female, predominantly young adults and many mothers. This partly reflected the demographic of those who attended the concert and those who were waiting to collect them at the Arena. Men were primarily in the responder, physically injured and bereaved groups; some survivor groups were women only.

Results

The feedback at stage 1 – initial recruitment – highlighted consistent themes and confirmed managers' understanding of what was drawing people to the groups. More than 90 per cent of respondents agreed with the following statements:

- They wished to meet with people who had been through a similar experience.
- Information shared in the group would help them understand and make sense of their reactions and behaviour.
- Meeting others would make them feel less isolated in their thoughts and feelings.
- They would like to know more about tips for helping them cope with loss, trauma and staying resilient.

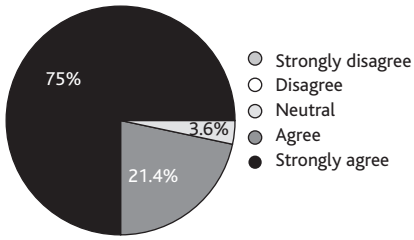
Figures 1 and 2 show how, after six sessions, levels of agreement with the four themed statements remained high (80–98 per cent over the four statements at stage 2, based on a 47 per cent response rate; and 83–100 per cent over the four statements at stage 3, when the local groups ended, based on a 40 per cent response rate). When asked whether they would recommend a similar support group programme for people affected by future major incidents, all respondents (100 per cent) agreed that they would.

Qualitative feedback complemented the quantitative data. Participants were invited to comment on how attending the group meetings had been helpful for them. As well as enabling them to voice, understand and manage feelings such as guilt and fear, respondents suggested it gave them a sense of:

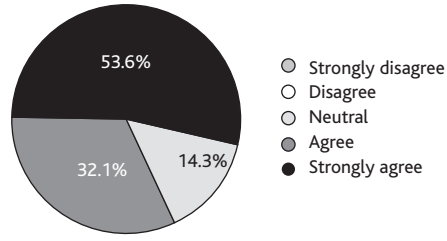
- community (feeling 'less alone'; meeting other people who have been through the same thing);
- security;
- acceptance (not feeling 'shamed or judged'); and

Figure 1: Support group members' feedback after six sessions

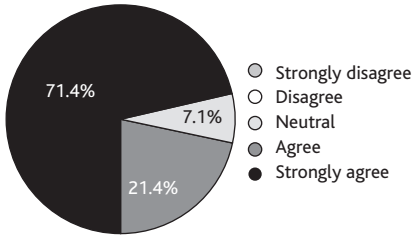
The support group is enabling me to meet with people who have been through a similar experience as me.
28 Responses



Meeting others is helping me feel less isolated in my thoughts and feelings.
28 Responses



Information shared in the group is helping me understand and make sense of my reactions and behaviour.
27 Responses



Through the group I am learning about tips for helping me cope with loss and trauma and staying resilient.
27 Responses

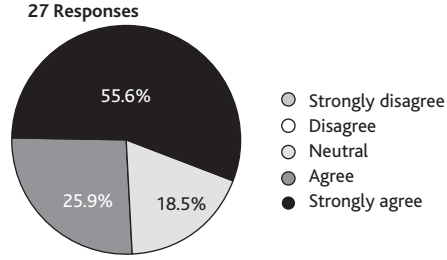
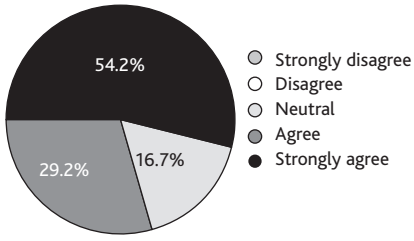
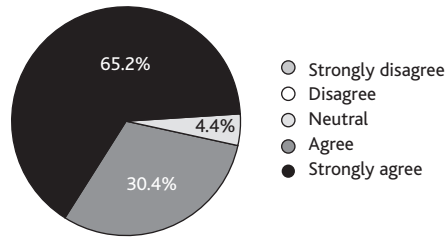


Figure 2: Support group members' feedback at the end of the local group meetings

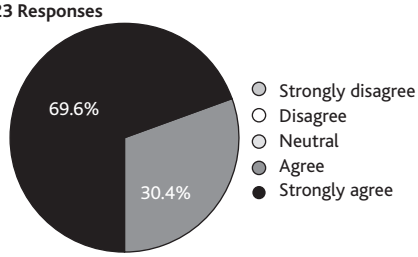
Through the group I learned about tips for helping me cope with loss and trauma and staying resilient.
23 Responses



Meeting others helped me feel less isolated in my thoughts and feelings.
23 Responses



The support group enabled me to meet with people who have been through a similar experience as me.
23 Responses



Information shared in the group helped me understand and make sense of my reactions and behaviour.
24 Responses

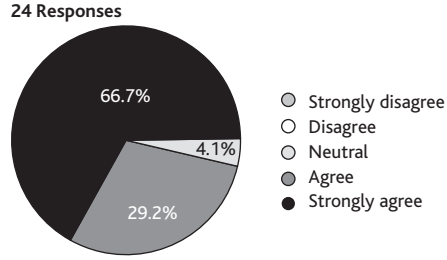


Figure 3: Wordcloud reflecting participants' feedback through a creative ritual, January 2020

- being mutually supported ('the group has been there for me'; 'able to be heard as well as support those in the group too'; 'can speak freely about how the attack has/is affecting us').

The role of facilitators was also singled out for comment by some in relation to passing on some key coping skills (for example, breathing techniques, visualisation and understanding levels of consciousness) and enabling the members to work closely to support one another. The role of facilitators was also singled out for comment by some in relation to passing on some key coping skills (for example, breathing techniques, visualisation and understanding levels of consciousness) and enabling the members to work closely to support one another. In the words of one participant: 'The BEST thing to come out of this terrible attack was these groups – with fantastic, supportive, caring coordinators. THANK YOU'.

Over the course of the programme, feedback from both open-ended survey questions and the workshops demonstrated consistently high satisfaction rates in terms of programme aims and expectations. Key themes included a strong and shared sense of feeling safe, supported, validated, listened to, not forgotten and less alone; a sustained sense of feeling cared for; feeling better able to cope with loss and trauma; and feeling more resilient. Figure 3 presents a wordcloud reflecting participants' thoughts and feelings about their groups and discussions, gathered through a creative ritual at the end of the first all-group workshop in January 2020.

Discussion and recommendations

From its inception, the MASGP was modelled on a psychosocial approach and grounded in evidence-based principles for enhancing psychosocial resilience and efficacy after collective trauma. Operationalising those principles in programme design and delivery promoted an environment of safety, calm, efficacy, connectedness and hope. Participation in the regional groups enabled bereaved people, survivors and responders to share and make sense of their experiences, benefit from mutual support and feel enhanced in their coping and resilience. The series of all-group events and workshops consolidated their sense of mutuality, solidarity and efficacy, which has culminated in the development of a self-sustaining peer support network.

While peer support and post-disaster support groups are not new, the programme was an incident-specific creation and novel in the landscape of UK post-disaster psychosocial support in terms of being bespoke and incident-specific and its scale. Through a multidimensional focus, the programme leaders achieved a hybrid approach, drawing on the skills of professional facilitators while at the same time staying faithful to original, peer-developed meanings of peer support.

The limitations of the programme included its timing (only achieving funding and rollout after the first anniversary) and the extent of its reach and take-up proportionate to the numbers affected by the attack. An independent review would have enabled the analysis here to extend beyond the feedback gathered within the programme. Further research might address this and also compare the experiences and long-term wellbeing and resilience of the cohort studied with those affected by terrorism and other collective trauma events who have not had access to or participated in this kind of psychosocial support opportunity. There is also a need for the development of peer support standards to assist those developing or accessing post-disaster support.

In conclusion, the MASGP models a psychosocial response that complements professional mental health services in providing relief from trauma and enhancing peer support and recovery following disaster. It is recommended that greater awareness and understanding of this type of programme is provided to mental health, emergency planning and other professionals with a role to play after collective trauma events. Furthermore, in line with guidance around psychosocial aftercare, humanitarian assistance and recovery strategies should embed and resource this kind of psychosocial response as complementary to individually focused mental health needs assessments and pathways.

Notes

1 From Disaster Action's launch document.

2 Despite the creation in 2017 of a cross-government Victims of Terrorism Unit (VTU), the UK campaign group Survivors against Terrorism reports continuing shortfalls in the resourcing, coordination and effectiveness of support services based on its members' experiences (Survivors against Terrorism, 2022). The importance of learning from the lived experiences of victims is also underscored in a report by Lord Harris (Harris, 2022) which reinforces the continuing need to ensure the resourcing, coordination, maintenance and access to post-incident support services as part of terrorism preparedness in and beyond London.

[3] During the first year following the Arena attack, the two originators of the programme had provided expert advice to responding organisations addressing humanitarian impacts and the support needs of those affected. As hybrid professionals, their consultative role was grounded in their own rich personal histories and professional experience of the impact of interventions following disaster and a keen sense of responsibility for ensuring that those affected by traumatic grief and loss receive the most appropriate longer-term support. One is a sociologist specialising in psychosocial aspects of disaster and humanitarian assistance and a survivor of the Hillsborough disaster in 1989. The other is an accredited psychotherapist specialising in disaster trauma, terrorism and homicide and a bereaved family member from the September 11 attacks.

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Conflict of interest

The author declares that there is no conflict of interest.

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