BMJ -
Decision on
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Body: 04-Jan-2019

Dear Dr. Allsopp,

BMJ-2018-047774 entitled "Responding to mass casualty terror attacks in UK mental health services: How have things changed since the 2005 London bombings?
A comparison of the NHS mental health responses to the terrorist attacks on the London (2005) and Manchester (2017), identifying service developments and ongoing barriers that urgently need addressing"

Thank you for sending us this paper and giving us the chance to consider your work.

We sent it out for external peer review and discussed it at the Analysis manuscript committee meeting (present: Peter Doshi, Paul Simpson, Navjoyt Ladher, Emma Rourke)

Although the topic is of interest, after careful consideration we have decided not to publish your paper. Unfortunately, we do not feel the current manuscript is going to work for The BMJ.

The reviewers' reports are available at the end of this letter. The editors comments are listed below:

The article is timely and likely to be of interest to a broad readership, however, there was a lot of descriptive detail without sufficient analysis. We felt that the article was structured around the authors' experience, rather than being structured around the key points with the authors' experience being used to augment the argument. We would also have expected more discussion of the international literature, as emergency response is something that is relevant worldwide. The article needs to be accessible to a non-UK readership, and explain terms like IAPT and gold commander.

While we recognise that the comments from editors and reviewers may help guide a revised paper, we think the revisions would essentially amount to a new paper. You may wish to send your paper to a different venue rather than taking on a substantial revision, especially as we are not able to guarantee that we will pursue it.

If you do wish to resubmit a revised paper amended in the light of our and/or reviewers' comments, please use the resubmission link below. When submitting your revised manuscript please provide a point by point response to our comments and those of any reviewers. I must stress that resubmitting your manuscript does not guarantee eventual acceptance, and that your resubmission may be sent again for review.

As you will appreciate we receive a large number of articles and often have to reject valuable and worthwhile work. When making an editorial decision we take the comments of the reviewers into account and also consider whether a piece will interest and inform our readers and whether it adds sufficiently to previous work. We have a large volume of Analysis submissions competing for limited space at the moment and have to make difficult decisions about which papers to accept.

I'm very sorry for any disappointment caused and hope that the outcome of this submission does not deter you from future submissions to The BMJ.

Best wishes,

Emma Rourke
ERourke@bmj.com

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Please see our policy and the unified Competing Interests form http://resources.bmj.com/bmj/authors/editorial-policies/competing-interests. Please state any competing interests if they exist, or make a no competing interests declaration.

Reviewer(s)' Comments to Author:

Reviewer: 1

Recommendation:

Comments:
Mass violence incidents including terrorist attacks appear to be occurring with increasing frequency, and they pose challenges to healthcare and mental health care providers and systems as well as to the communities in which they occur. This paper is difficult to evaluate on some levels because it is not a research paper per se but more of a "think piece" paper that describes two mass violent incidents, the responses to each, makes comparisons about differences in response to the second vs the first, and continuing barriers to providing mental and other healthcare services to victims and survivors of mass violence incidents.The paper is timely and contains some useful information, and the series of actions the authors identify on page 5 of the manuscript are quite valuable. However, the paper would be improved substantially by a revision that addresses the following issues.

First, there is insufficient conceptual structure and organization to assist the reader in putting the response to these two mass violence incidents into proper perspective. It be helpful to have it bit more discussion of what an adequate mental health response to mass violence incidents might look like and how this response might vary depending on characteristics of the incident or victims affected (e.g. those that involve criminal justice system activity due to survival are the perpetrator versus those that do not; age range of victims and survivors; whether most victims and survivors live near the location where the incident occurred versus those that are dispersed geographically and will require long-term follow-up services in multiple locations). The point needs to be made that the characteristics of the incident itself need to be analyzed carefully in order to determine what victim needs are likely to be and that the service delivery system will have to be adjusted based on this information. For example, cases in which perpetrators survive

frequently involve protracted criminal justice system procedures that require special assistance to victims throughout this long process, highlighting the importance of partnerships with criminal justice system agencies to ensure that evidence-based, victim-centric planning and assistance is available at all stages. If incidents occur at concerts, sporting events, etc., it is likely that many if not most victims and survivors will not live near where the incident occurred, so provisions must be in place to provide services to victims who are geographically dispersed.

Second once this framework of best practices and needs has been described, the two mass violence incidents described in the paper can be compared to this template, which will facilitate the reader being able to determine the adequacy of response to each one and the extent to which the response to the second incident improved on the response to the first incident.

Third, an alternative way of organizing the paper would be the following. Start with an overview of policies, procedures, or best practices that were in place prior to the 2005 incident. Next, describe what was done and learned on the basis of response to that incident. Next, describe policies/procedures/best practices recommendations that were made based on experience with the 2005 incident. Two documents were mentioned in the paper that appeared to have such recommendations, and it would be helpful to include more information about these. Next, describe what was done in response to the 2017 incident but also make clear which of the previous recommendations were either not in place or could not be implemented in the 2017 incident. Finally, conclude with the analysis of what old recommendations still need to be implemented and what new recommendations should be added based on experience with the 2017 incident.

Third, it would be helpful for readers who are not familiar with the UK health system for the authors to provide a bit more information/explanation about the system and terms that are specific to it. Similarly, the section starting at the bottom of page 2 describing failure to share data because of concerns raised by the data protection act is not clear. It is unclear whether the authors believe that data were not shared enough, were shared too much, or some combination of the two. More information about this would be helpful. I also think it would be helpful to provide a bit more information about the Manchester Resilience Hub. What is it? What is that supposed to do? What services does it provide? How is it organized?

In summary, this paper provides some valuable information, but it could be strengthened substantially by a revision that addresses these issues.

Additional Questions:
Please enter your name: Dean G. Kilpatrick Ph.D.

Job Title: Distinguished University Professor

Institution: Medical University of South Carolina

Reimbursement for attending a symposium?: No

A fee for speaking?: No

A fee for organising education?: No

Funds for research?: Yes

Funds for a member of staff?: No

Fees for consulting?: No

Have you in the past five years been employed by an organisation that may in any way gain or lose financially from the publication of this paper?: No

Do you hold any stocks or shares in an organisation that may in any way gain or lose financially from the publication of this paper?: No

If you have any competing interests <A HREF='http://www.bmj.com/about-bmj/resources-authors/forms-policies-and-checklists/declaration-competing-interests'target='_new'> (please see BMJ policy) please declare them here: I do not believe this constitutes a conflict of interest, but I am Principal Investigator on a large grant from the United States Department of Justice Office for Victims of Crime that established the National Mass Violence and Victimization Resource Center, I am also PI on another grant from the Office for Victims of Crime that was funded to provide a broad array of mental health and other services to individuals affected by the 2015 Mother Emmanuel AME Church mass murder shooting perpetrated by a white supremacist in Charleston, South Carolina.

Reviewer: 2

Recommendation:

Comments:

This paper compares the NHS mental health responses to the terrorist attack in London in 2005 to the more recent outreach program implemented in Manchester in 2017 and identifies developments and barriers in providing adequate services.

The authors point at extremely important challenges in responding to terror attacks in modern societies across the world. The identified ongoing barriers in England are equivalent to challenges in European societies and I recommend the paper to be accepted in BMJ to inform clinicians, researchers, decision makers and authorities.

The paper is well structured and easy to read and understand.

I have some comments and suggestions for the authors to consider in revising the manuscript.

1. Introduction:
After describing the two terror attack events in the UK, the authors sum up possible impacts of terror attacks as follows:
"The majority of people may experience short-term distress, but generally cope well, however, some may have more persistent distress, and a sizeable minority may develop difficulties consistent with psychiatric diagnoses.(4,6)
The latter is particularly common for people with past mental health difficulties.(4)"
Ref:
4. NHS. NHS Emergency Planning Guidance: Planning for the psychosocial and mental health
care of people affected by major incidents and disasters: Interim national strategic guidance
30-7-2009.DH. 2009;95.
6. NATO Joint Medical Committee. Psychosocial care for people affected by disasters and major
incidents. 2008;0–139.

In a scientific paper I would prefer references from original sources in regard to these estimates, and preferably from studies on populations being exposed to terror attacks or comparable events. The event in Manchester comprised of 27% children and young adults, so this could also be considered in choosing sources.

I agree with the authors that some studies have concluded that past mental health difficulties predict development of psychiatric diagnoses in disaster survivors, but the evidence of this statement in young terror survivors is questionable. At least, the authors should refer to original research papers making the sources of evidence more accessible to the readers.

2. The London Bombing and the Manchester Arena 2017 attack
I am well familiar with the outreach program implemented after the London Bombing in 2005. This work set new standards for planning and implementing support and health services to exposed populations after terror attacks across Europe. Unfortunately, terrorist attacks account for increasing and substantial numbers of deaths and disability. Also, European societies are experiencing a dramatic and continuing increase in number and catchment of terrorist attacks and related deaths, accompanied by a substantial increase of terrorism-related costs. This trend is expected to continue as home-grown right-wing and jihadist extremists, lone-wolfs, and returned foreign fighters from conflict zones are considered to pose a substantial security threat in Europe in the years to come.
Hence, European societies need to raise their standards on how to identify victims and reach out to affected populations. In this paper the authors both demonstrate what has been implemented since 2005 and important issues that are still unsolved.

Regarding the description of the Manchester Arena 2017 attack, I have the following comments;
1. Being a non-UK reader, I have some difficulties understanding the health care system in the UK and what exactly "Strategic clinical network" and "Improving Access to Psychological Therapies" actually means. Please describe for international readers.
2. The authors describe tremendous efforts made to identify victims for registration in a database. Still, I understand that only 3200 persons were identified compared to 19 500 persons present at the attack. This demonstrates the need for improvements. Do the authors through their work see unused potentials for identifying affected citizens, e.g. by mobile phone or other measures?
3. Line 50-54 on page 3: I understand the hub got responses based on their needs. Can the author describe in more detail what kind of responses this was and how they selected out those in need of more than automatic email responses? Referrals were made to evidence-based services close to where they lived. How do the authors know that the services provided evidence based services - also to children and young adults in the population? Please make a reference to evidence of the statement that the access to evidence based therapy has vastly improved since 2005.

3. Barriers and addressing challenges
The first barriers to care for civilians being hit by terror and suffering from posttraumatic stress reactions are distressing reading; funding and identifying suffers. These are barriers for politicians and other authorities to address and solve, and I complement the authors for addressing these issues.
These barriers needs to be solved to succeed in implementing outreach programs and provide adequate services.
Implementing care pathways for all victims, regardless of age or where they live, and designed for the specific events, is challenging. To continuously update our knowledge on the potential psychosocial, mental and somatic impact of these events, more documentation is needed, both from outreach programs and clinical experiences and from rigorous research studies. This paper addresses important issues in these ongoing challenges.

4. Suggested addition sources

From the terror attack in Oslo, I allow myself to recommend the authors to look into the experiences made from the 2011 outreach program in Norway, as this may be useful additional knowledge.

1. Dyb, G., Jensen, T. K., Glad, K. A., Nygaard, E., & Thoresen, S. (2014). Early outreach to survivors of the shootings in Norway on the 22nd of July 2011. European Journal of Psychotraumatology, 5. doi:10.3402/ejpt.v5.23523
2. Dyb, G., Jensen, T. K., Nygaard, E., Ekeberg, Ø., Diseth, T. H., Wentzel-Larsen, T., & Thoresen, S. (2014). Post-traumatic stress reactions in survivors of the 2011 massacre on Utøya Island, Norway. British Journal of Psychiatry, 204(5), 361-367. doi:10.1192/bjp.bp.113.133157
3. Bugge, I., Dyb, G., Stensland, S., Ekeberg, Ø., Wentzel-Larsen, T., & Diseth, T. H. (2015). Physical injury and posttraumatic stress reactions. A study of the survivors of the 2011 shooting massacre on Utøya Island, Norway. Journal of Psychosomatic Research, 79(5), 384-390. doi:10.1016/j.jpsychores.2015.09.005
4. Hafstad, G. S., Thoresen, S., Wentzel-Larsen, T., Maercker, A., & Dyb, G. (2017). PTSD or not PTSD? Comparing the proposed ICD-11 and the DSM-5 PTSD criteria among young survivors of the 2011 Norway attacks and their parents. Psychological Medicine, 47(7), 1283-1291. doi:10.1017/S0033291716002968
5. Haga, J. M., Stene, L. E., Wentzel-Larsen, T., Thoresen, S., & Dyb, G. (2015). Early postdisaster health outreach to modern families: a cross-sectional study. BMJ Open, 5:e009402. doi:10.1136/bmjopen-2015-009402
6. Stene, L. E., & Dyb, G. (2016). Research participation after terrorism: An open cohort study of survivors and parents after the 2011 Utøya attack in Norway. BMC Research Notes, 9(57). doi:10.1186/s13104-016-1873-1
7. Stene, L. E., & Dyb, G. (2015). Health service utilization after terrorism: A longitudinal study of survivors of the 2011 Utøya attack in Norway. BMC Health Services Research, 15(1). doi:10.1186/s12913-015-0811-6
8. Stene, L. E., Wentzel-Larsen, T., & Dyb, G. (2016). Healthcare needs, experiences and satisfaction after terrorism: A longitudinal study of survivors from the Utøya attack. Frontiers in Psychology, 7:1809. doi:10.3389/fpsyg.2016.01809
9. Thoresen, S., Jensen, T. K., Wentzel-Larsen, T., & Dyb, G. (2016). Parents of terror victims. A longitudinal study of parental mental health following the 2011 terrorist attack on Utøya Island. Journal of Anxiety Disorders, 38, 47-54. doi:10.1016/j.janxdis.2016.01.004

Additional Questions:

Please enter your name: Grete Dyb

Job Title: Professor, Research Director

Institution: University of Oslo/ Norwegian Center on Violence and Traumatic Stress Studies

Reimbursement for attending a symposium?: No

A fee for speaking?: No

A fee for organising education?: No

Funds for research?: No

Funds for a member of staff?: No

Fees for consulting?: No

Have you in the past five years been employed by an organisation that may in any way gain or lose financially from the publication of this paper?: No

Do you hold any stocks or shares in an organisation that may in any way gain or lose financially from the publication of this paper?: No

If you have any competing interests <A HREF='http://www.bmj.com/about-bmj/resources-authors/forms-policies-and-checklists/declaration-competing-interests'target='_new'> (please see BMJ policy) please declare them here: I am not sure I understood this completely. So I will make sure I disclose here: I am employed by the University of Oslo/Norwegian Center of Violence and Traumatic Stress Studies. I have no competing interests with the authors of this paper. Our research on the 2011 terror attack in Oslo has resulted in many research papers (40-50 peer review papers), but I do not see this as a competing interest. There is a tremendous need for research in this area.

Reviewer: 3

Recommendation:

Comments:
This paper explains the mental health responses to the two major incidents in UK and discusses about their differences and the challenges extracted from them. These challenges are common in disaster mental health responses also in the other countries and important to be shared widely in an academic field.

Minor comments

Key message 1 seems overstatement. This paper discusses about the differences in the mental health responses following the two major incidents. The differences mentioned in the paper were mainly stem from the differences in the two incident characteristics. The responses to the 2017 attack was not necessarily "improved". If there are any concrete "development" or "improvement" in disaster mental health responses in UK since 2005, please explain it.

Please explain about "IAPT" briefly in the text (p3, l51).

In the text, "596 adults returned at least one questionnaire" (p2, l47), but the corresponding number in Table 1 was 565. Why?

Additional Questions:
Please enter your name: Maiko Fukasawa

Job Title: Project researcher

Institution: The University of Tokyo

Reimbursement for attending a symposium?: No

A fee for speaking?: No

A fee for organising education?: No

Funds for research?: No

Funds for a member of staff?: No

Fees for consulting?: No

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