Dear Editors,

RE: Revision of BMJ-2019-050533 "Responding to mental health needs after mass casualty terror attacks"

Thank you for the opportunity to revise the above article. The editorial team highlighted numerous interesting points throughout the paper that required clarification, expansion, or further detail. We have addressed these issues as far as possible according to our current knowledge, and taking into account the limitations of the word count. Below we give an outline of how we have addressed the key questions raised by the editorial team. We are grateful for the additional review; this did not include any requested amendments so we have focused here on the response to editors.

London bombings, 2005

We have now named the NHS Trust and mental health policy unit involved in the mental health response to the London 2005 bombings. We have provided further information about a capacity assessment that was conducted, which established the need for a specialist service to be set up, and details about when funding for the service was sought. We have clarified how the questionnaire measures were anchored to the attack, and provided more information about the types of mental health difficulties assessed in the screening assessment. We have briefly expanded our statement about the Data Protection Act to confirm that, whilst data sharing was permitted in these circumstances under the legislation, the failure to share data was due to a failure to appreciate this could be lawfully done.

Learning from international terrorist attacks

We have expanded on the detail given about the response to the attacks in Norway, Paris, and the UK programme set up to support British citizens affected by the Tunisia, Paris, and Brussels attacks. For the account of the Norway response, these amendments included more information about the mental health teams and where these were based. The nature of the Utøya Island attack was such that the young people affected were identified by their presence on the island for a summer camp, and as such, identification and obtaining contact details does not appear to have been an issue in the same way as the London and Manchester attacks. Similarly, due to the targeting of young people in the attack, the outreach response specifically included family members in addition to the young people themselves. We have amended the account of the response to take into account these factors. We have also clarified the wording around who had communication with an assigned contact person during the first 15 months after the attack. It appears that whilst the majority had initial contact, this contact was not maintained between the initial response period and 15 months post-incident.

Clarification was sought regarding the mental health services available after the Paris attacks. The French have an existing system of medicopsychological support teams (‘CUMPs’) that work alongside traditional emergency services and provide psychological support after traumatic events. It was these services that were mobilised after the incident, and we have added some wording to clarify this process in the text.

We have outlined further information about the UK programme set up to support British citizens affected by the Tunisia, Paris, and Brussels attacks, clarifying the reasons for the delay in its setup, and the organisations responsible for delayed data sharing. The wording has been clarified around people ‘screening positive’ on questionnaire measures; this is defined as having a clinically significant score (according to established thresholds) on at least one of the measures used, such as PTSD.

Manchester Arena, 2017

We have outlined further detail about the model on which the Manchester Resilience Hub was based, which included the London 2005 screen and treat service and the UK programme set up to support British citizens affected by the Tunisia, Paris, and Brussels attacks, as well as expertise from local Military Veterans Services on dealing with IED blast injuries. Patient feedback about the speed of the response in London was also taken into account, and these factors have all been included in the manuscript. The Hub was led by the devolved Greater Manchester Health and Social Care Partnership (HSCP), jointly run by the NHS and local government, and this has been outlined in the text. Details of each questionnaire used for adults and children have been outlined, including clarification about how risk was defined and identified. The age range of young people support by the Hub has been clarified, and further information given about the Hub activities, including a central role being clinicians referring nationally to help people access therapy close to their homes, and further information about the well-attended trauma-informed family days run by the Hub. The location of these days is determined by local need and client geography as 80% of clients live outside of Greater Manchester.

Where are we now?

Some of the points in this section were more difficult to clarify, and this is in part due to the central questions raised by this analysis article: several key issues remain unresolved and we do not know why they have not yet been addressed. These unanswered issues include:

- why mental health planning exercises and pre-agreed financial mechanisms have not been resolved
- who is responsible for commissioning and whether this discussion is on anyone's agenda
- why concessions made in the Data Protection Act for data sharing in these situations have not always been complied with
- why Public Health England has not completed plans to write a health register protocol for mass casualty incidents

We feel that to attempt to answer these questions would involve speculation, which we are wary of doing. For example, we feel that there is a perception of tension between the Civil Contingencies Act (2004) and requirements related to GDPR – even if this perception is erroneous – such that organisations are wary of sharing data in case this violates individuals' data protection rights. In addition, members of the author team have advocated for a central register yet it remains unresolved as to why this work has not been completed. We would be happy to add some statements to this effect if required by the editors, but we would need to be clear in the article that we are suggesting these as speculation only.

Addressing these challenges

It is our experience that issues are international and therefore irrespective of health service organisation, and we have added a statement to this effect.

We hope that these amendments sufficiently clarify and expand upon the queries raised by the editorial team. We have tried hard to answer the editors' questions and add these additional details whilst also keeping the word count close to 2000 words. We edited down the article to 2265 words and hope that this will be acceptable.

Please let us know if you require any further amendments or clarifications.

Yours sincerely,

Kate Allsopp (on behalf of all authors)