Critical incident services post-NICE

Dr Michael Reddy, chair of ICAS, discusses the trend to de-pathologise post-incident responses

These notes are drawn from the experience of one EAP provider (ICAS) of crisis intervention in many different parts of the world over a period of 20 years. During that time ICAS teams have operated continuously in the majority of West European and some East European countries, in South America, in some African countries and in the Far East. With our colleagues in all these countries and from our partner companies in Israel and Australia we have learned and shared a great deal. Over time we have evolved a set of documented, tried and tested operational protocols.

The broad and diverse situations that form the background to our practice include the inevitable terrorist attacks in Northern Ireland and mainland Britain, Spain, Nigeria, Indonesia and Pakistan. It's a long list, as is the even longer list of road, aviation and rail disasters throughout the world, or the endless examples of local (nightclub, forecourt and retail site) violence, refinery explosions, the inevitable but occasional natural catastrophe, and so on, all of which we have dealt with. Critical incidents (CI) are part and parcel of daily life for EAPs in many parts of the world.

In the process of learning what works and what doesn't we have had to structure our CI services as a separate business unit within ICAS, partly because its invoicing system (fee for service) is different from the EAP capitation process, but largely for operational reasons. Past experience of large-scale and prolonged crisis situations (earthquake, rail disasters, prison riot) has persuaded us that the demands of an extended disaster can over-extend the normal clinical resources of our national service centre. So we have ring-fenced the CI service and given it a separate call centre with its own incident room. It wasn't only that our clinical resources could be pulled out of shape in extreme situations but also that the site management tasks are more varied and intensive in themselves and call for tighter procedures to connect base with on-site practitioners, with the police and the media.

We are of course still consistently challenged by every new incident, as we were in the recent tsunami disaster. A dedicated CI service has to be acknowledged as an area of evolving expertise and over the last several years our Milton Keynes and Glasgow teams have continually stepped back to review and revise our protocols, working arrangements and personnel in the light of quality control, emerging best practice, new legislation and risk management. What follows represents some of our most recent thinking, which (encouragingly and coincidentally) mirrors fresh advances in CI theory and practice in the US.

The two main aspects of the current approach of ICAS teams in various parts of the world are the nature of CI work as a whole and a focus on the period immediately after an incident, now popularly called psychological first aid, and also known as first response, normalisation or stabilisation.

The nature of CI work

There has been a re-framing of the way we construe our work as CI specialists. There is nothing revolutionary about this but it brings some notable shifts in emphasis in that, for example, we now catalogue the skills and experience package we bring to our corporate clients under three heads: stabilisation, assessment and treatment. We also look for a wider range of skills and training in those who work with us.

The stabilisation and treatment aspects of the ICAS approach can be considered as two ends of a time spectrum. Insofar as there is a recognisable stretch of time between them it will begin from the moment we pick up the phone from a client when our first concern will be to stabilise the situation. Later, treatment and treatment plans will gradually emerge, very much on an individual basis. Where post-traumatic stress disorder (PTSD) is identified (by definition after a minimum of four weeks) and in accordance with NICE (National Institute for Health and Clinical Excellence) guidelines it will lead to a programme of roughly 12 CBT (cognitive behavioural therapy) sessions. By this time we expect the significant aspects of stabilisation to be behind us.

ICAS had in any case been modifying its approach to debriefing for a number of years, precisely to eliminate the dangers of re-traumatisation and secondary traumatisation, and we have of course now abandoned all forms of group debriefing. At the same time we are aware that the last word has not yet been said, if only because NICE guidelines must always be taken as work in progress. It is also possible that the DSM4 diagnostic categories will be reviewed and revised at some time in the future.

Our 20-year experience has made ICAS wary of an overly rigid approach to any aspect of CI intervention including timescales. The third component of our

Dr Michael Reddy is chair of ICAS
mreddy@icasgroup.com

CI approach (assessment), for example, is an integral aspect of the service from the very beginning rather than a phase, and remains central to the process throughout, while it progresses from informal to increasingly formal diagnosis. Treatment too will gradually move from initial early and intuitive response into planned palliative and supportive tactics and then, where necessary, to more focused forms of treatment where the impact of the event has proved resistant to a more normal process of gradual recovery. The trajectory of the ICAS approach to critical incident management from immediate first response to particular refinements of treatment for those more seriously affected may take weeks and for a very small minority even months. The timeline is dictated only by the widely varying needs of individuals as they appear.

Psychological first aid

The second aspect of our approach highlights the stabilisation phase as a time and situation requiring a particular range of skills – the skills of critical incident management rather than critical incident therapeutic intervention. Whether we are already on site or are responding by phone to an urgent call from a client company, we speak more now about stabilising a situation, not just individuals. Our primary task is to help a business to recover, help an organisation refocus on its objectives, help an organism recover its functionality. Of course individuals will be forefront but they are individuals in context. There are many instances in CI work where making it a priority to restore the context – to underpin management and other support services – is the best start we can give to individuals.

We always employ trained clinicians for this work and offer them additional training but the way they are deployed is not typical of the ordinary work of clinicians even though it is illustrative of the way ICAS teams now construe their task. As clinicians our attention is naturally drawn to individual psychological need. For many clinicians it is something of a paradigm shift to consider the systemic aspects of a situation first, and not all of them get there easily or have had the experience to instinctively react to the broader organisational issues that may intrude.

More difficult still for some of us is the need to sacrifice our normal way of intervening – perhaps with some programmatic psychological intervention in mind. Initially we may even have to forget we are clinicians, abandon the cloak of clinical expertise and be responsive at an intuitive, spontaneous, human and pragmatic level. If that means making sure someone has a hot drink or or is desperate for us to find some information, if someone needs a taxi or if heavy boxes need moving, then that's what we do. If it means attending first to managers and others who carry a duty of care and health and safety responsibility for their employees and help them rediscover their authority – then that is what we must do first. It sounds simple even if it isn't what we are instinctively good at.

Flexibility is an absolute requirement for the onsite clinician and many of our associates have developed a talent for the sort of creativity every new situation demands. There still isn't a rule-book for CI response in the immediate aftermath of an incident.

The second talent that the onsite clinician needs is a strong stomach for the heart-rending and obscene things they will have to hear and see, and maybe smell and touch – often well outside the range of normal experience. They will have to respond to outpourings or grief, anger, panic and guilt as well as deal with catatonic stupor and helpless paralysis. This kind of resilience comes best from personal experience – including one's own difficult transitions in life – as well as previous clinical experience.

We still haven't settled on a name for this stabilisation period. A list of 30 tasks a group of us produced inside five minutes to describe the sort of things we might actually have to do when we arrive onsite included:

- meeting and greeting
- helping people get in touch with others
- providing information
- comforting and consoling
- letting people talk
- letting people not talk
- making urgent referrals
- getting individuals' details
- helping people look forward rather than back
- protecting from further hurt
- eliciting other people's help and resources.

That's only a start. Someone suggested 'social welfare' would cover most of the tasks but in the end we will probably call ourselves First Responders. We really do want to de-clinicalise ourselves at this early stage. If we have to wear a badge onsite then 'Support team' is as good as anything.

Our tendency to diagnose and pathologise may be second nature but it doesn't help in circumstances where each and every reaction is technically 'pathological'. Even 'psychological first aid', which is already acquiring the cachet of an acronym (PFA!), suggests that: 'My you really are ill! The best I can do is patch you up a bit till you can get some real help.' The medical model has dominated psychological thinking for more than a century. It will eventually take its place alongside others, hopefully before another century has passed. ■

STOCKBYTE GOLD/ALAMY