

Isn't it NICE to be ignored when you're stressed?



ILLUSTRATION WORKS/NIGEL SANDOR

John Durkin exposes the dangers of a rigid adherence to National Institute for Clinical Excellence (NICE) trauma guidelines and merits the use of peer-support interventions

Critical incidents as 'foreseeable hazards'

In keeping with health and safety principles, a foreseeable hazard is an avoidable hazard, or at least one that should be prepared for. Critical incidents are those incidents that carry the potential to overwhelm an individual's psychological coping abilities; where coping is not restored, exaggerated fears and dread can follow as self confidence and a sense of control become eroded. Talk to anyone who has gained a diagnosis of Post Traumatic Stress Disorder (PTSD) and they could probably tell you about 'the moment everything changed', their inability to do anything about it and how unhappy life became afterwards. If such a reaction is foreseeable following a work related incident it is, according to health and safety criteria, avoidable and/or be prepared for. This logic, however, appears to present a contradiction for mental health at work in the light of 2005 guidelines on the treatment of PTSD, as the following example may show.

NICE guidelines

A seminar entitled Critical Incident Stress Management: crisis-intervention through peer-support was run in Ely, Cambridgeshire in March, 2006 for the region's fire and ambulance services. It was disrupted by a 'trauma counsellor' who strongly objected to the use of crisis-intervention in any circumstances. Additionally, he informed the room, anything perceived as 'debriefing' was likely to find its advocates in legal hot water on the basis of 'published research'. He claimed that anyone addressing traumatic stress was bound by the

National Institute for Clinical Excellence (NICE) guidelines (Gaskell & The British Psychological Society, 2005a)¹. The NICE guidelines advise against single session debriefing in favour of 'watchful waiting' in the aftermath of a stressful incident. After the passage of four weeks, those with symptoms of concern are to be referred for Trauma focused Cognitive Behavioural Therapy (TF-CBT), Eye movement Desensitisation and Reprocessing (EMDR) or drug therapies as treatment.

Cochrane review

The NICE guidelines incorporated earlier research findings and recommendations published as a Cochrane Review (another medically-focused body of information that promotes evidence-based practice) entitled Psychological Debriefing for the Prevention of Post Traumatic Stress Disorder (Rose, Bisson & Wessely, 2002)² which focused on two studies that concluded that psychological debriefing was ineffective and potentially harmful. The studies cited referred to the original Mitchell paper on Critical Incident Stress Debriefing (CISD) (Mitchell, 1983)³ for emergency service personnel, a peer support model, and adapted it for use with hospitalised burns patients (Bisson, Jenkins & Alexander, 1997)⁴ and road traffic accident victims (Mayou, Ehlers & Hobbs, 2000)⁵, evidently not peer support models. No evidence (to the author's knowledge) of training was provided to demonstrate the competence of the research teams given that CISDs are group-based interventions (see over) employing trained and experienced peers and a mental health professional as a team. In both studies, individual research staff carried out 1:1 interviews with

John Durkin became a psychologist after 17 years as a firefighter. He is an accredited trainer of Critical Incident Stress Management and Chair of the Research & Studies Committee of the Traumatic Incident Reduction Association. He currently runs FireStress, a stress and trauma resolution service for the UK emergency services.
john@firestress.co.uk

recently-injured victims undergoing medical treatment; hardly a fair comparison if the findings become generalised in the way that they have been in the emergency services. The article Critical Incident Services post-NICE in the Summer 2005 edition of *Counselling at Work* shows a not uncommon response, 'and we have of course now abandoned all forms of group debriefing' (Reddy, 2005)⁶.

Together the NICE and Cochrane Review publications appear to support the idea that PTSD should be targeted with specific treatments as it is not preventable and that psychological debriefing should be abandoned. One curiosity about the zeal with which the NICE recommendations have been pursued, particularly amongst occupational health staff, counsellors and psychotherapists working outside the NHS, is the irrelevance of the guidance to their work. To quote the public information booklet on the NICE guidelines (author's italics for emphasis):

This information describes the guidance that the National Institute for Clinical Excellence (called NICE for short) has issued to the NHS on the treatment and care of people with Post Traumatic Stress Disorder (PTSD). It is based on Post Traumatic Stress Disorder (PTSD): the management of PTSD in adults and children in primary and secondary care, which is a *clinical guideline produced by NICE for doctors, nurses and others working in the NHS in England and Wales*. (p.3; Gaskell & The British Psychological Society, 2005b)⁷

If you are not '...a doctor, nurse or other working in the NHS,' it was not written for you. If any UK employer had a duty to treat PTSD in their staff they would surely have a duty to diagnose it too, in which case the Health & Safety Executive (HSE) would probably be issuing its own guidance on how to do it. UK employers are not obliged to maintain mental health by treating PTSD in their employees, they are obliged to identify, act on, and monitor risk.

Risk assessment and critical incident stress management

Taking a simple risk assessment viewpoint, three phases should be considered.

- i. Identify the hazard;
- ii. Intervene to eliminate or minimise the hazard; and
- iii. Monitor the effect of the intervention.

Critical Incident Stress Management (CISM) is a

strategic model of crisis intervention that covers all the points of risk assessment for mental health following a critical incident. Crisis intervention can be thought of as 'psychological first aid' as it requires personnel to undertake specialist training to produce a skill base of interventions to prevent their colleagues' symptoms from worsening and to assist their recovery. It does not replace mental health professionals, any more than first aid replaces doctors, but where effective it may prevent the need for that higher level of care; where it does prove necessary that referral would be made. Staff trained in crisis intervention will be able to employ crisis communication skills with their colleagues to assess the impact (if any) that a critical incident has had on them. Where the impact appears to threaten their competence or abilities, a checklist of tactics of acknowledgement, stabilisation and encouragement can be employed.

For example with a firefighter experiencing a stress reaction at an incident, a trained peer would engage in a private communication to assess and motivate that individual. Where recovery did not occur, removal from the scene and additional assistance would be sought. Back at the station, a 20-45 minute 'defusing' with the crew using trained colleagues would take the risk assessment process a stage further including the prospect of organising a Critical Incident Stress Debriefing (CISD) should it appear necessary.

Were a CISD to be called, at least two peers and a mental health professional would form a team to undertake this structured crisis intervention with the crews who were exposed to the incident. Invitations would be made to those who were involved to report their thoughts and feelings at the job and the effect it had had on them since. The mental health professional would bring their expertise to the group and look for additional evidence of risk. They would educate on issues that seemed pertinent to the people involved and participate in stress management advice and follow-ups so that monitoring of those involved remained ongoing.

Peer support

And so the risk assessment process is complete using credible well trained peers with support from mental health professionals. This is the model that enabled the entire New York Police Department (NYPD) to be supported by some form of crisis intervention following the 9/11 attacks. It was the model that was employed by the same officers to deal successfully with a suicide problem that developed in the mid-90s. Those who took responsibility for addressing the suicide problem

were themselves New York police officers insisting that the only people who understood the stress of a New York police officer, were New York police officers, and peer support was used to address it.

Peer counsellors at the Fire Department of New York (FDNY) now teach their colleagues to look out for potential indicators of distress such as where their colleagues' lifestyles change them from 'fat to fit, or fit to fat'. Attempts to combat intrusive memories from critical incidents through over exercise or over eating are likely to be noticed by colleagues long before a psychologist gets to ask whether the incident has led to any changes in lifestyle.

‘Watchful waiting’ is like telling firefighters to stop doing first aid at road accidents and wait to see who gets worse before requesting an ambulance

Trauma risk management

One interesting development in recent years has been the Trauma Risk Management (TRiM) system that seems to differ from Critical Incident Stress Management (CISM) mainly in its use of peers to deliver assessment rather than to provide support and intervention. It seems therefore that in risk assessment terms only the first criterion – identify the hazard – can be satisfied by TRiM because referral is made to professionals rather than intervening directly there and then. If an organisation has sufficient mental health staff trained and competent to deal with all the likely referrals (as perhaps military organisations do) then maybe the intervention and monitoring demands can be met by in house mental health staff. However, in organisations that do not have sufficient mental health professionals (see *below*) and/or have to await PTSD treatment through the NHS it begs the question, what else can be done? With staff trained in crisis communication techniques and available in sufficient numbers to offer peer support by meeting a distressed colleague with minimal delay the development of symptoms that could precipitate PTSD can be interrupted. As TRiM ‘...does not aim to prevent or treat PTSD’ (p.25, Langston, 2005)⁸ it does not appear as an optimistic model of recovery before the passage of several weeks and then joining a waiting list prior to 8-12 weeks of treatment.

Resources

Following the 9/11 attacks when it was reported that stress-related injury in the Fire Department of New York had increased 17-fold, the author carried out a survey of UK fire services to determine the number of operational staff (including officers and fire control) employed, and the number of psychologists trained to treat PTSD that were under contract to their brigade. The ratio of staff to psychologists was over 2,600:1. According to the NICE guidelines TF-CBT and EMDR would be expected to run once a week over 8-12 weeks. If it is foreseeable, it should be avoidable so if the stress injury count in your organisation increased 17-fold after a large scale terrorist incident, where would you find the treatment resources if you followed the NICE guidelines? And how would you defend the decision in a court to follow them rather than meet your health and safety requirements through risk-assessment?

The British Psychological Society (BPS) reported on the implications of the findings of the Cochrane Review of psychological debriefing, and included some legal considerations of employing, and failing to employ, interventions that could be described as ‘debriefing’ (British Psychological Society, 2002)⁹. In Chapter 7, *Psychological Debriefing and Legal Issues*, it points out that if an intervention is believed to be beneficial, there is a legal obligation not to withhold it (Wheat, 2002)¹⁰. In other words if you think it works, it should be provided; watching and waiting for symptom-development could be ethically and legally unsound.

Despite the irrelevance of NHS guidelines to the emergency services, effective peer support strategies are being dropped by police, fire and ambulance services in favour of ‘watchful waiting’ or in this author’s view, neglect. With around 20% PTSD rates in sections of the UK fire service (Durkin & Bekerian, 2002)¹¹, it is only peer support that is available to a high risk group who choose to remain on duty despite their symptoms. To debunk crisis intervention tactics following a critical incident in favour of ‘watchful waiting’ is like telling firefighters to stop doing first aid at road accidents and wait to see who gets worse before requesting an ambulance. Even if you told them not to, I expect they would still try something. With training in crisis intervention at least they would be relieved of the frustration of inaction, and at best, if suicide was a prospect for their distressed colleague, they might save a life. ■

References

1 Gaskell & The British Psychological Society (2005a) Post-traumatic Stress Disorder: The management of

- PTSD in adults and children in primary and secondary care. National Clinical Practice Guideline Number 26.
- 2 Rose, S., Bisson J. & Wessely S. (2002). Psychological debriefing for preventing post-traumatic stress disorder. The Cochrane Library – 2002, Issue 1.
- 3 Mitchell, J.T. (1983) When disaster strikes... The critical incident stress debriefing process. Journal of Emergency Medical Services. 8. (1). 31-39.
- 4 Bisson, J.I., Jenkins, P.L. & Alexander, J. (1997). Randomised controlled trial of psychological debriefings for acute burn trauma. British Journal of Psychiatry, 171, 78-81.
- 5 Mayou, R.A., Ehlers, A. & Hobbs, M. (2000). A three-year follow-up of a randomised controlled trial of psychological debriefing for road traffic accident victims. British Journal of Psychiatry, 176, 589-593.
- 6 Reddy, M (2005) Critical Incident Services post-NICE. Counselling at Work, Summer 2005.
- 7 Gaskell & The British Psychological Society (2005b) Post-traumatic stress disorder (PTSD): the treatment of PTSD in adults and children Understanding NICE guidance – information for people with PTSD, their advocates and carers, and the public. Information about Clinical Guideline No. 26
- 8 Langston, V. (2005) Putting the Psychological Aspects of Trauma Management into an Organisational Context: a standardised approach. Counselling at Work, Summer 2005.
- 9 British Psychological Society (2002) Psychological Debriefing: Professional Practice Board Working Party, Leicester.
- 10 Wheat, K. (2002) Psychological Debriefing and Legal Issues . In Psychological Debriefing – Professional Practice Board Working Party, Leicester.
- 11 Durkin, J & Bekerian, D.A (2002) Organisational and Incident-related Factors in Stress in the Fire Service. University of East London. Unpublished thesis.



IRON MILL
INSTITUTE

Business Development
Counselling, Psychological
Supervision & Training

Featured Course

Options in Life, Business and Executive Coaching
IAC/ACC, IAC/ACC and allows membership to
IAC/ACC and additional American-based organisations

Many people who are already successful business owners
are looking to work through issues in the area of
coaching, with senior executives, team leaders and staff in
business. This course is designed to provide you with the
skills and working from a network, using the practical skills
to create an effective network and skills.

This course is experiential and gives ample opportunity for the
development of these qualities and experiences that makes
executive coaching such a great field. The course itself is led
by highly regarded practitioners with vast coaching and
life and stress management and organisational background.

Course Dates: January 2006

www.ironmill.info

STOCK ILLUSTRATION SOURCE/JAMES ENDICOTT



Workplace duty of care:

Do employers view workplace counselling as a shield against litigation or a weapon fighting for duty of care? **Peter Jenkins** investigates.

Duty of care is clearly the buzzword of the new millenium, just as 'workplace stress' was for many practitioners back in the nineties. Counsellors and their employers are currently struggling to define the limits to their respective duties and liabilities, in an uncertain and shifting legal landscape. In what the Daily Mail describes as 'the fevered casino atmosphere of Britain's compensation culture', it seems ever more important to be clear about what counsellors can (or can't) realistically achieve in providing effective care to staff in the workplace.

The changing face of employment provides a sobering backdrop to this sudden flurry of interest in duty of care issues. According to research carried out by the Chartered Management Institute this year, Britain is suffering from employment patterns dominated by job insecurity, long hours and pressure of work. According to Professor Cary Cooper, of Lancaster University, 'we are seeing a short-term contract culture added to a long-hours culture'. An estimated 33 million working days are lost due to stress at work, more than 60 times the amount lost via industrial action. According to the TUC, bullying now causes the loss of 18 million working days, with managers being identified as the bully responsible in three-quarters of the cases involved.

A compensation culture?

Added to this potent mix, there is the emergence of a