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Psychiatric Bulletin (2003), 27, 145–147

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Service innovations

The Cardiff traumatic stress initiative: an evidence-based approach to early psychological intervention following traumatic events

There remains uncertainty on how best to respond to the psychological needs of individuals following traumatic events. Various approaches have been tried, but there is now a growing body of research in this area that allows us to plan appropriate responses in an evidence-based and coordinated manner. This paper describes the development of a local initiative through a partnership between the local traumatic stress service and the emergency planning department.

There has been considerable debate on what to provide and how in the way of a psychosocial response following a traumatic event. The lack of clarity and agreement in this area was highlighted by the variation in responses following the 11 September 2001 terrorist attack in New York. Decisions on what to provide have usually been based on anecdotal evidence and the strong human urge to do something, often resulting in the uncoordinated mobilisation of counsellors who offer interventions such as debriefing shortly after the trauma to anyone willing to engage with them.

Every local authority in England and Wales has an emergency planning officer, whose key role is to develop an emergency plan. The emergency planning officer coordinates the Disaster Management System, a multi-agency, multi-professional partnership in which emergency services (ambulance, fire and police) play a central role. Other agencies, including the local authority, social services, health and voluntary agencies, support the emergency services. In order for their input to be effective, this support should be delivered in a pre-planned coordinated manner and integrated into the central plan.

Emergency disaster plans often include a well-developed 'non-psychological' emergency response, but little, if any, detail about the psychological response, perhaps reflecting the Home Office's (1998) *Dealing with Disasters* document that merely states 'victims of disasters should be offered psychological support'. This paper describes the development of an evidence-based, early psychological response through a partnership between the local emergency planning department and traumatic stress service.

The evidence base

The evidence base in this area is becoming more robust. A Cochrane systematic review (Rose *et al*, 2001) of one-off early interventions within a month of the traumatic event has now identified 11 randomised controlled trials, including a total of 1759 individuals. The results are neutral when analysed overall and strongly suggest that one-off interventions should not be offered routinely.

Five studies of more complex early interventions have now been published (see Bisson (2001) for a review). Most have focused on brief (1–6 sessions) cognitive-behavioural therapy. A total of 574 individuals have been included and, overall, there appears to be a positive effect, especially for those presenting with early traumatic stress symptoms. Bryant *et al* (1998) only included individuals with acute stress disorder and showed those who received five 90-minute sessions of cognitive-behavioural therapy (CBT) to be far less likely to go on to develop post-traumatic stress disorder (PTSD) at 6 months than those who received supportive counselling (17% versus 67%).

The evidence that a brief cognitive-behavioural early intervention does work is far from certain, being based on the results of relatively small trials, mainly from one researcher in one centre. However, it seems reasonable to conclude that brief cognitive-behavioural early interventions may be beneficial and should be primarily aimed at individuals with acute symptoms, as opposed to everyone involved in a traumatic event.

The Cardiff plan

In order to develop a specific plan for Cardiff, a coordinating group was created involving the local emergency planning officer, the consultant psychiatrist and clinical psychologist from the local traumatic stress service and a representative from social services. This group meets approximately four times per year.

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Immediate response

Should a major traumatic event occur, the most important immediate response for victims is practical and pragmatic support. This would be delivered primarily by social services, the emergency services and the voluntary sector. Through training organised by the coordinating group, the individuals involved should have received basic education about the post-trauma psychological response and how to deal sympathetically and empathically with individuals. There is no requirement for the presence of mental health professionals at the scene, although they should be easily contactable, as those managing the response may find it useful to discuss some issues with a professional in this area. In addition, some individuals may require immediate support, for example, for extreme anxiety or psychotic reactions. At this time, an accurate database of those involved, either directly or indirectly, would be created and maintained by a member of the emergency planning department. Individuals felt to be at highest risk of developing a problematic response would be flagged to allow proactive follow-up.

Formal planning meeting

Within 48 hours of the incident, the coordinating group would meet to agree how to adapt the outline plan for the specific incident. Decisions would be made regarding the size of the response and which elements of the plan should be mobilised. The meeting would also review the pre-written information leaflet about the early post-traumatic response, personalise it to the specific incident and arrange for it to be distributed to those on the database.

Telephone helpline

A telephone helpline for emotional support, staffed by the local telephone branch of the Samaritans, would be activated in addition to the information helpline. A separate telephone line, funded by the emergency planning department, has been installed in the Samaritans' building for this purpose. The Samaritans already possess excellent telephone counselling skills through their core work, and receive ongoing traumatic stress training from members of the coordinating group. They would receive regular supervision (initially on a daily basis) from mental health professionals within the coordinating group. In addition to receiving telephone calls, they would proactively ring those who had been flagged on the database. Those at highest risk and/or who were extremely distressed would be offered an appointment with a trauma counsellor.

Trauma counsellors

A team of 10 volunteer trauma counsellors has been created as part of the local initiative. All the counsellors are employed by an NHS Trust or social services department and have a mental health or formal counselling qualification as a minimum requirement. Training days are held twice a year. Initially, these focused on an

introduction to traumatic stress, then on the delivery of a brief cognitive-behavioural intervention and now on dealing with more complex issues. In addition to attending training days, the counsellors are expected to take on a client from the local traumatic stress service and attend a supervision group at least once a month to develop their skills. Following a major trauma, the counsellors would assess individuals identified as being at high risk of psychological sequelae and provide brief interventions for those with prominent traumatic stress symptoms. They would receive regular supervision from the consultant psychiatrist and clinical psychologist.

Initial assessment

The assessment performed by the trauma counsellors would be semi-structured and this, ideally, would occur approximately a month after the trauma. At initial interview, the individual's symptoms and their impact on functioning would be assessed, and significant cognitive themes and related affective responses would begin to be identified. Particular attention is paid to associated features such as prominent shame, guilt, anger and anxiety. Significant background issues would be explored. These include previous psychiatric history, social support systems, coping mechanisms and compensation issues.

Disposal

If the symptoms appeared to be settling, there would be no need for formal intervention. If prominent traumatic stress symptoms were present, then a brief cognitive-behavioural intervention would be offered (see below), dependent upon an assessment of the individual's ability to tolerate this. If other symptoms or issues dominated, the individual may be offered an alternative brief intervention, e.g. cognitive therapy/anxiety management for panic symptoms or referral to another agency, for example, substance misuse services or assessment for psychotropic medication.

Preparation for intervention

If significant traumatic symptoms are present, the rationale behind exposure and cognitive interventions would be explained. The individual's symptoms and reactions would be normalised and possible benefits of additional intervention would be discussed. Various techniques would be used to increase emotional and behavioural stabilisation, if this was needed. These would include anxiety management, grounding techniques, guided self-dialogue (Foa & Rothbaum, 1998) and building on existing adaptive coping strategies.

Brief intervention

The brief intervention for early traumatic stress symptoms was designed as a four-session intervention for a randomised controlled trial (the manual is available from the authors on request). The intervention involves education about the normal post-trauma response,



construction of a script of exactly what happened in the first-person present-tense, including thoughts, feelings, sights, smells, noises, emotions and physical reactions. The script is read repeatedly for homework, then audio-taped and listened to repeatedly. Distorted cognitions are challenged and *in vivo* exposure is used if individuals are avoiding real-life situations. In the final session, the participant is given a written summary of the intervention that outlines successes, areas for attention, potential problem areas and how to cope with these and any other relevant details.

In the majority of cases, individuals will be discharged following the brief intervention, with a follow-up contact arranged for 3 months later. In some cases, the intervention needs to be offered over a longer time frame and it is continued. While the ideal is to offer a short, discrete intervention, this should not be at the expense of developing the therapeutic relationship or providing intervention based on a formulation of the presenting issues.

Traumatic stress clinic

If further intervention is required, the individual will be assessed by a mental health professional in the traumatic stress clinic and receive evidence-based management as clinically indicated. Usually, this involves further CBT, pharmacotherapy, eye movement desensitisation and reprocessing or a combination of treatments.

Other services

It is likely that other services would be provided at times. For example, we may offer a group-educational session on traumatic stress following the traumatic event. We may also be involved in the creation and support of self-help groups and other initiatives in the medium term.

Discussion

We believe that the Cardiff Traumatic Stress Initiative offers a pragmatic, deliverable evidence-based approach to providing an early psychological response following a major traumatic event. The strengths of our initiative include its pre-planned nature, the ongoing training and supervision of those involved and the fact it has been

developed, and will continue to be developed, in partnership with the agencies who would be involved should a major traumatic event occur.

In reality, it is impossible to determine how effective the initiative will be until it is put into practice. Even well-planned initiatives can fail following a traumatic event, with multiple agencies becoming involved and uncoordinated general supportive counselling dominating the psychological response. Other potential difficulties include the creation of an accurate database that includes all individuals involved, which can be used to distribute information and proactively follow up those at highest risk of psychological sequelae, while adhering to the Data Protection Act. The Samaritans' ability to detect those individuals at highest risk is another important issue and, hopefully, this will be made possible through the ongoing training programme and close supervision, should the helpline be implemented. Finally, the brief cognitive-behavioural intervention would be delivered by trauma counsellors with less experience than the clinical psychologists who delivered the intervention in Bryant *et al's* trials. Again, we believe that the ongoing training and supervision programme should maximise the chance of these counsellors being effective.

We see this initiative as an early step towards the ultimate goal of ensuring that early psychological interventions following traumatic events are evidence-based and effective.

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