From accidents to assaults

How organisational responses to traumatic incidents can prevent post-traumatic stress disorder (PTSD) in the workplace

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From accidents to assaults

How organisational responses to traumatic incidents can prevent post-traumatic stress disorder (PTSD) in the workplace

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Since the beginning of the century there has been a growing awareness of the psychiatric impact of certain severe stressors on an individual's ability to function effectively, in both their personal and professional lives. In more recent years, attention has been focused on the psychological consequences for those exposed directly to, or working in the aftermath of, extremely traumatic incidents. There has also been much recent debate around trauma management and the treatment of traumatic symptoms.

This report is the second of two commissioned by the Health and Safety Executive. It considers current understanding of trauma and the extent to which it can affect employees in a wide range of jobs.

Findings are presented from case study research in 17 organisations, covering a diverse range of occupations. Organisational responsibility and the legal implications of trauma are explored. An overview is provided of current knowledge on the efficacy of the different trauma management practices. Different approaches to the management of risk, and the treatment of PTSD and trauma related mental health, are identified and discussed.

The report then moves on to consider the way forward for trauma management practices, and conclusions and recommendations from the research are presented.

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IES aims to help bring about sustainable improvements in employment policy and human resource management. IES achieves this by increasing the understanding and improving the practice of key decision makers in policy bodies and employing organisations.
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This is a report of work undertaken by a number of researchers from different institutions, led by the Institute for Employment Studies. The team included Dr Jo Rick, Project Manager at the Institute for Employment Studies; Dr Andrew Guppy, Reader at Liverpool John Moores University; and Dr Kathryn Young, a Senior Research Fellow at UMIST at the time of the research.

The project was conducted on behalf of the Health and Safety Executive (HSE).
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Executive Summary

Introduction

This research was commissioned by the Health and Safety Executive to assess current levels of knowledge and practice in the management of workplace trauma. The specific objectives were to:

- provide a comprehensive picture of current knowledge about the impact of traumatic incidents on employees' mental health
- establish the extent to which there is consensus on those forms of response that work best
- assess whether the research evidence is sufficient to provide general guidance on best practice for employers.

This is the second of two research reports. The first presented findings from the literature review. This report focuses on trauma management practice in a range of UK organisations, and incorporates findings from the literature review to highlight activities that can be considered good practice, given present levels of knowledge.

The context of this report

PTSD is the term commonly used to refer to the reactions that some people experience in the aftermath of an extreme incident. In fact, a diagnosis of PTSD is often difficult — only a small proportion of people will be diagnosed. However, many more are likely to experience some traumatic symptoms.

We normally think of PTSD as only occurring after highly traumatic or distressing incidents, such as the Hillsborough disaster, but research clearly shows that people can experience traumatic symptoms in relation to far more everyday occurrences (eg car crashes).

For organisations, trauma is an area of direct relevance both from a legal point of view and from their need to support traumatised staff while continuing to operate efficiently and effectively.
The extent to which trauma is a risk to different occupations is not consistently documented. Much work has focused on more crisis prone organisations (e.g. work that involves the potential for incidents that could be considered traumatic, e.g. the emergency services) and consequently the extent of trauma in non-emergency organisations is difficult to judge with any great accuracy.

Many workers may be exposed to traumatic experiences with varying frequency; other occupations may expose workers to sequential, but less individually devastating trauma.

In addition, the nature of traumatic experiences can vary considerably. Certain jobs have known and repeated traumatic events, for example, those who may experience bank raids in the financial sector. Other jobs may risk exposure to extreme events (e.g. emergency services) whereas others involve contact with the public where there is a risk of violence.

**Risk assessment and traumatic incidents in the workplace**

Unlike assessment of physical hazards where the harm caused is more likely to be direct and objectively measurable, assessment for psychosocial hazards (which include traumatic incidents) is complicated by a number of issues including, for example, individual differences in response to the same degree of exposure.

Risk assessment for psychosocial hazards was less apparent than for physical hazards in the case study organisations visited. However, several had or were in the process of developing procedures for more accurate monitoring and assessment.

The risk from hazards will vary from workplace to workplace and their potential for causing harm will vary from person to person. This makes it difficult to produce a comprehensive list of potential hazards that should be assessed for. However, there is a degree of consensus over types of work that need to be considered.

Most importantly, organisations need to consider the methods they have available to them in conducting risk assessment. Much help is available in the form of pre-existing checklists and guidance on, for example, task analysis.

**Pre-incident activities**

Case study organisations demonstrated a variety of different approaches to minimising the risk of traumatic incidents at work. These included selection and recruitment procedures that ensured applicants had a clear idea of the demands of the job they were applying for, and ensuring teams have the right skill mix.
Thorough risk assessment can identify jobs where there are specific risks or skill needs. These can then be dealt with through appropriate training or job redesign.

Other forms of training and preparation fell into four broad areas. On the preventative side, there was fairly widespread use of security measures, such as CCTV, as well as training in preventing incidents from occurring. Other pre-incident activities involved training in how to respond to incidents (eg bank raid drills) and education on the potential reactions to a traumatic incident and the support that was in place.

Managing the post incident response

Activities fall naturally into two broad categories: those associated with managing during or in the immediate aftermath of an incident, and those aimed at longer term management of reactions to the incident.

Regardless of length or type of incident, diffusing (or defusing) was a common way for staff to deal with the incident. Diffusing tended to be naturally occurring and happen on an informal basis.

With only four exceptions among the case study organisations visited, debriefing was used in the days following an incident to help people deal with their feelings and to prevent the development of PTSD.

In practice, the way debriefing sessions were conducted varied greatly from organisation to organisation, and differed from the original protocol set out for dealing with trauma in emergency service personnel. However, all debriefing activity was characterised by the following two points:

• that in some way debriefing would lessen the likelihood of subsequent traumatic symptoms, and

• that the debriefing process itself involved, at some stage, intense re-exposure to the incident.

Despite its widespread use, it is not at all clear that debriefing benefits trauma victims. Some evaluations have suggested that it can cause more harm, by retraumatising individuals. Current thinking suggests that one of the reasons debriefing could be detrimental is that it involves people in intense re-exposure to the incident and that this could act as a secondary source of trauma.

Despite this, the processes around debriefing (ie acknowledging individuals have experienced an extreme event, clearly identified procedures to follow, and ongoing monitoring of staff well-being) are widely welcomed within organisations.
Recommendations

Context of the report

To understand the scale and nature of difficulties, attention should be focused on the experience of traumatic symptoms rather than diagnoses of PTSD.

Employers should be encouraged to undertake thorough risk assessments to identify workplace hazards which could lead to the experience of traumatic symptoms.

Risk assessment and psychosocial hazards in the workplace

Assessment of psychosocial hazards needs to build up a picture based on several different sources of information including the hazards themselves, the evidence that they cause harm, and the management procedures already in place.

Organisations should be encouraged to investigate how well existing reporting procedures reflect the true situations within their organisations.

It is essential to establish the causal links between hazards and harm if risk assessment is to be effective.

Pre-incident activities

Organisations should be encouraged to review pre-incident activities on a regular basis and should identify any informal practices of merit which could be promoted at a corporate level.

Regular rehearsal of emergency or critical incident procedures should be encouraged to ensure that in the event, staff will know the protocol to follow.

Managing the post-incident response

Organisations not already doing so formally should explore the potential benefits of diffusing, and identify whether such an approach is appropriate to their organisational setting.

It is essential that organisations have very clear and measurable aims for any post-incident intervention, against which performance of the intervention can be judged.

The jury is still very much out on debriefing. Organisations who wish to use this procedure should also set in place proper evaluation procedures to ensure that debriefing is meeting the objectives set for it.
If no appropriate evaluation is possible then it would be advisable to consider dropping the intense re-exposure to the incident from the process.

Debriefing should not be mandatory, but participants should be encouraged to go as the processes of understanding what happened and sharing experiences are rated as extremely helpful by debriefing participants.

The need to hold debriefing sessions within a specific time frame is not substantiated and there is some suggestion that allowing time prior to debriefing can be productive.

Overall

A key aspect of this good practice is that it was rare to find one initiative working alone. In virtually all organisations visited, there was a package of measures in place including: risk assessment, selection and recruitment measures, training and education, rehearsal of critical incident procedures, clearly defined practices and policies for managing incidents wherever possible, clear guidance on dealing with the immediate aftermath of an incident, as well as longer term support for employees. All of these approaches, adapted to differing organisational needs, serve to reduce the likelihood of incidents occurring and to minimise the harm when they do.
1. Introduction

1.1 Background

Since the beginning of the century, there has been a growing awareness of the psychiatric impact of certain severe stressors on an individual’s ability to function effectively in both their personal and professional lives. In more recent years, attention has been focused on the psychological consequences for those exposed directly to, or working in the aftermath of, extreme incidents. Recent research has demonstrated the extent to which individuals can be exposed to trauma in a wide range of occupations. There has also been much recent debate around workplace trauma management and the treatment of traumatic symptoms.

The pattern of harm which follows traumatic events has to some extent been charted, although not without great (and ongoing) debate on both the definition and parameters of Post-Traumatic Stress Disorder (PTSD). As a result, psychologists and psychiatrists are now turning their attention to developing responses that serve to minimise further psychological harm, post-trauma. However, different research approaches, in different settings, have produced varying findings on the efficacy of treatment. As a result, persuasive evidence about which responses work best, and whether their efficacy can be replicated across different work settings, is limited.

With this in mind, the HSE commissioned a research project to help clarify these issues and to determine whether sufficient is now known to offer employers guidance on best practice. The full research objectives are set out in detail in the following section.

1.2 Research objectives and methodology

The objectives for the study were laid out at the start of the research project. The primary objectives were to:

- provide a comprehensive picture of current knowledge about the impact of traumatic incidents on employees’ mental health
- establish the extent to which there is consensus on those forms of response which work best
• assess whether the research evidence is sufficient to provide
  general guidance on best practice for employers.

A collection of methodological tools were chosen to achieve
these objectives. In particular:

• a review of the literature to date
• establishing, through case studies, current best practice
• analysis of expert opinion using the Delphi technique.

Since then, the HSE has decided that the original proposal — for
one report which covered all of the objectives — could be bettered
by separating the literature review element of the research from
the fieldwork. Workplace Trauma and its Management: Review of the
Literature was published by HSE Books in May 1998.

This report is the second of the two, and presents findings from
the fieldwork.

Information is presented from three main sources:

• Case study evidence and data from interviews with experts in
  the field have been presented on an anonymous basis.

• Descriptions of named organisations from published reports
  are used for illustration and are presented in dotted-line text
  boxes. These illustrations should not be confused with the case
  study organisations participating in this research, and the
  source material for each is identified at the bottom of the box.

• Findings from the Delphi exercises with managers and trauma
  survivors are presented in double-bordered shaded boxes.
  These illustrate individuals’ reactions to their experiences and
  are not the views of the report authors.

The gaps between the experiences of Delphi respondents and
what can be achieved (as demonstrated by the case study
evidence) highlight the types of work or areas for development
that may well face many organisations.

1.3 Structure of the report

Chapter 2 provides an introduction to PTSD and traumatic
symptoms. It provides an overview of the legal perspective on
trauma and employers’ responsibilities under the Health and
Safety at Work Act. It also provides evidence on exposure to
trauma in the workplace.

Chapter 3 examines risk assessment and the role it has to play in
minimising harm to employees. It also presents the approaches
to risk assessment used in different settings.
Chapter 4 considers the range of activities that organisations undertake to prevent an incident from occurring, or to minimise the likelihood of an incident escalating. It looks at selection and recruitment practices, training, security measures, major disaster plans and information/education on responses to trauma.

Chapter 5 reviews the way in which organisations respond to workplace incidents, from practices and procedures immediately after an incident, to longer term staff support. It considers the efficacy of different approaches and the ongoing debate about the use of debriefing to prevent the development of trauma symptoms.

Chapter 6 presents the conclusions from the research and recommendations for future practice.
2. The Context of this Report

Key points

- PTSD is the term commonly used to refer to the reactions that some people experience in the aftermath of an extreme incident.
- In fact, a diagnosis of PTSD is often difficult — only a small proportion of people will be diagnosed. However, many more are likely to experience some traumatic symptoms.
- We normally think of PTSD as only occurring after highly traumatic or distressing incidents, such as the Hillsborough disaster, but research clearly shows that people can experience traumatic symptoms in relation to far more everyday occurrences (e.g., car crashes).
- The number of people who will experience significant problems following exposure to a traumatic incident is hard to gauge. Some estimate the number is as high as 30 to 40 per cent (Raphael, 1986).
- Estimates of the prevalence of the disorder among the general population also vary. Reviews of the data on lifetime prevalence have suggested estimates ranging from 1.3 per cent (Rick et al., 1998) to five per cent in males, 15 per cent in females (Wessley et al., 1998).
- Because extreme stressors can take the form of a wide range of incidents, e.g., accidents at work or assaults, it is impossible to know the true extent of work-based trauma and more research is needed to clarify the issue.
- For organisations, trauma is an area of direct relevance both from a legal point of view and from their need to support traumatised staff while continuing to operate efficiently and effectively.
- There is no specific provision in the Health & Safety at Work etc. Act 1974 to deal specifically with psychiatric illness, but the statutory duties apply to individuals' psychological as well as physical well-being.
- The extent to which trauma is a risk to different occupations is not consistently documented. Much work has focused on more crisis-prone organisations (e.g., work that involves the potential for incidents that could be considered traumatic, e.g., the emergency services) and consequently the extent of trauma in non-emergency organisations is difficult to judge with any great accuracy.
- Many workers may be exposed to traumatic experiences with varying frequency; other occupations may expose workers to sequential, but less individually devastating trauma.
- In addition, the nature of traumatic experiences can vary considerably. Certain jobs have known and repeated traumatic events; for example, those who may experience bank raids in the financial sector. Other jobs may risk exposure to extreme events (e.g., emergency services) whereas others involve contact with the public where there is a risk of violence.
- Adequate risk assessment is essential for employers to fully understand the nature of psychosocial hazards relevant to their workers.
General awareness of Post-Traumatic Stress Disorder (PTSD) has grown rapidly in recent years. Recognition of the disorder has been very recent in medical terms.

In 1980, the American Psychiatric Association published the third edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-III). Here, for the first time, Post-Traumatic Stress Disorder was defined as a classifiable psychiatric syndrome.

The definition of PTSD has undergone several refinements since then, and there are now two working definitions available: DSM-IV (1994), and the International Classification of Mental and Behavioural Disorders (ICD-10), published by the World Health Organisation.

2.1 What is PTSD?

PTSD is the name given to the cluster of symptoms still being experienced by some individuals at least one month after threat of death or personal injury to the individual or a loved one, or learning about such an incident, and experiencing a horrified, fearful or helpless response to the incident (see Table 2:1).

In other words, to be suffering from PTSD, an individual must have had a horrified/helpless or fearful reaction to an extreme threat, and one month later still be experiencing symptoms from the following three clusters of symptoms:

- persistent, re-experiencing of the traumatic event
- avoidance of reminders of the event and feeling numb; and
- hyperarousal or increased startle response.

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<thead>
<tr>
<th>Post-Traumatic Stress Disorder</th>
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<td>ICD-10 and DSM-IV (APA, 1994) are the two alternative diagnostic tools available to practitioners working with people exposed to traumatic events. One of the most important aspects of the current definitions is that they go beyond the symptoms, and recognise the impact of the condition upon both the individual and those they must interact with. In this respect, and of particular relevance to this research, occupational functioning is now specifically mentioned in DSM-IV (APA, 1994).</td>
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<tr>
<td>The current definitions are the result of many research studies, and no doubt both the definitions of PTSD and diagnostic criteria will continue to be revised in the light of continuing research.</td>
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<td>With the introduction of PTSD into the International Classification of Diseases, the diagnosis became available world-wide. However, the slightly later DSM-IV (APA, 1994) definition is more rigorous in terms of both the definition of trauma and the qualifying symptomatology. It is important to be aware of which of the various definitions are being used when a diagnosis of PTSD is proposed, or when considering reports of the proportion of people who suffer from the disorder.</td>
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<td>General</td>
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<td>Definition of traumatic event</td>
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<td>The ‘Clapham omnibus’ test? (ie would the event cause distress to most reasonable people?)</td>
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2.1.1 How widespread is the problem?

In fact, diagnosis of PTSD is nearly always difficult, and can be masked by other problems. This means it is very difficult to get a reliable estimate of how many people suffer. At present, the best estimates suggest that less than one per cent of the general population suffers from PTSD at any one time, and not all of these will have suffered as a result of a work-related incident. Having said that, a far larger proportion are thought to suffer from ‘sub-clinical’ traumatic symptoms, i.e. they have some but not all of the symptoms associated with PTSD, either as a result of an extreme threat, or as a result of more minor but ongoing sources of distress.

2.2 When a reaction to trauma isn’t PTSD

DSM-IV (APA, 1994) offers other potential diagnoses to practitioners faced with people who have suffered extreme trauma. In addition to PTSD, Acute Stress Disorder and Adjustment Disorder are available within the scheme. However, the guidelines state that:

'Some symptomatology following exposure to an extreme stress is ubiquitous and often does not require any diagnosis.'

(DSM-IV, p. 431)

2.2.1 Acute Stress Disorder

Given that some reaction to a traumatic event is to be expected, ASD should only be considered if the symptoms:

- last at least two days, and
- cause clinically significant distress or impairment to social, occupational or other necessary functions.

From this, it is possible to infer that reactions to traumatic events which last for very short periods — for example, two days — are normal reactions.

Essentially, the symptoms of ASD closely mirror those of PTSD, except for the duration of the disorder. If the symptoms of ASD persist for longer than one month, the diagnostic guidelines suggest a diagnosis of PTSD should be considered.

2.2.2 Adjustment Disorder

A clarification of the relationship between PTSD and Adjustment Disorder is provided in the Differential Diagnosis for PTSD:

'In Post-Traumatic Stress Disorder, the stressor must be of an extreme (i.e. life threatening) nature. In contrast, in Adjustment Disorder, the stressor can be of any severity. The diagnosis of Adjustment Disorder
is appropriate both for situations in which the response to an extreme stressor does not meet the criteria for Post-Traumatic Stress Disorder (or another specific mental disorder) and for situations in which the symptom pattern of Post-Traumatic Stress Disorder occurs in response to a stressor that is not extreme (e.g., spouse leaving, being fired).

(DSM-IV, p. 427)

In other words, Adjustment Disorder provides a ‘catch all’ diagnosis, where either:

- the response to a traumatic event lasts longer than two days and does not fulfil the diagnostic criteria for Acute Stress Disorder, or
- PTSD symptoms are observed in response to a less extreme stressor.

Responses to the Delphi exercise (see Appendix 1)

Trauma survivors also reported a range of reactions: emotional, physical, cognitive, and somatic, which could perhaps be better understood as Adjustment Disorder.

Emotional reactions included: fear of the future (specifically of going back to work), fear of going out alone, fear of the dark (specifically from being out of control in the dark at the time of the incident), fear of anybody coming up behind them or anyone running towards them.

Other emotional reactions included: feelings of isolation, great sadness, loss of confidence, hurt feelings and crying for no apparent reason.

Physical or somatic reactions included: continual shaking on returning home after the incident, feeling weak and shaky for weeks afterwards, palpitations, churning stomach and chronic fatigue.

Cognitive reactions included: amnesia type reactions, being unable to comprehend everything that was happening immediately following an incident, a desperation to remember, but an inability to do so, frequently imagining more terrible events happening, feeling in a dreamlike state, feeling out of control, and not wanting to face people.

2.2.3 Differentiating between the three

While all three (PTSD, Acute Stress Disorder and Adjustment Disorder) require the presence of a psychosocial stressor, PTSD and Acute Stress Disorder are characterised by the presence of an extreme stressor and a specific constellation of symptoms. In contrast, Adjustment Disorder can be triggered by a stressor of any severity and may involve a wide range of possible symptoms.
In summary, it is to be expected that people will have a severe reaction to a traumatic event, particularly in the first couple of days.

For people who display symptoms beyond this period of normal adjustment, there are three possible diagnoses — Adjustment Disorder, Acute Stress Disorder and PTSD. They can be differentiated by looking at the type of stressor, the constellation of symptoms and the duration of symptoms.

However, a diagnosis is seldom straightforward, and there is a need to be aware of the co-existence and interaction of trauma-related disorders with other mental health issues.

2.3 Why do organisations need to be concerned about trauma?

Two reasons of major importance should prompt organisations to be concerned about trauma. The first (and by far and away the most important among our case study organisations) was concern about the ability of staff to function on both a personal and a professional level, following an incident. A secondary concern was that of the legal implications for an organisation following a traumatic incident.

Responses to the Delphi exercise (see Appendix 1)

The normal day-to-day functioning of trauma survivors was restricted in the following ways: on-the-job concentration was affected; people reported feeling very uncomfortable in their environment, and needed to be looked after as they just felt lifeless and apathetic; physical appearance was often negatively affected; and there were limitations in functioning due to loss of confidence, inability to face people, and a fear of going out alone or being isolated.

All the above reactions and limitations in daily functioning were experienced and reported by trauma survivors, which illustrates just how varied reactions to potentially traumatic events can be. It can be suggested from this data that any of these reactions to an event would render employees unable, or at least be extremely restricted in their ability, to carry out their normal activities.

Employers need to be aware of the potential reactions to traumatic incidents and acknowledge the potential risk for their organisation if employees' performance is sub-optimal.

Additionally, from a legal perspective (following the Walker ruling discussed below), employers need to recognise in what way employees are vulnerable, and act responsibly.
2.3.1 Features of the civil law on trauma-induced psychological illness

These issues were recently addressed by the Law Commission (1995) in a consultation paper on liability for all psychiatric illness. Damages may be paid for shock-induced psychiatric illnesses other than PTSD, although the paper states that PTSD is increasingly prominent in personal injury claims.

However, the Law Commission notes that the DSM criteria are designed for clinical, education and research purposes, and therefore:

'It should be noted that... in most cases the clinical diagnosis of DSM-IV mental disorder will not in itself suffice to establish the existence of a mental disorder for legal purposes, owing to the imperfect fit between the questions that are of ultimate concern to the law, and the information that is contained in a clinical diagnosis.'

Law Commission, 1995, p. 39

The Law Commission outlines five key principles which identify who is liable to pay damages for psychiatric illness. They are essentially the principles which assess liability in cases of physical injury. The first, namely that the defendant owed the victim a duty of care, has proved the most problematic for plaintiffs. The remaining four are reasonably straightforward:

- The defendant's conduct was negligent.
- The negligent act caused the injury/illness (a diagnosis of PTSD includes causation, as this is part of the definition of the condition).
- The illness is not too remote from the event.
- The defendant has no defence.

As the law stands, there appear to be two further conditions to claims for damages for psychiatric illness.

Firstly, the plaintiff must suffer a recognised psychiatric illness. PTSD has been established as recognised in this context. Secondary victims of the trauma (i.e., those who do not directly experience the trauma, but come into contact with it through work [e.g., the emergency services] or through acting in a rescuer role) may also claim for shock-induced illnesses.

Secondly, it should have been reasonably foreseen by the defendant that her/his negligence would result in the plaintiff suffering a psychiatric illness.

Several other points of law are worthy of note in a discussion about PTSD. The plaintiff may recover damages if:
- the psychiatric illness arose from a reasonable fear of immediate physical injury to themselves
- the psychiatric illness arose from their role as a rescuer, or
- the psychiatric illness arose through fear of causing injury.

Employees not falling into the above categories can be classified as bystanders and are not seen as suffering directly from the incident (except perhaps as secondary victims) (IRB, 1995).

The Law Commission also suggests that a psychiatric illness induced by the shock of damage to property may be possible, although this has not been firmly established.

Although DSM-IV (APA, 1994) includes learning about threats to self and family in the definition of traumatic events, it is also not totally clear whether negligent communication of a catastrophic event, which causes shock-induced psychiatric illness, is compensatable.

However, the thorniest issue of the law on PTSD is that of proximity. If a defendant has imperilled or injured a third party (ie not the plaintiff or defendant) and the plaintiff suffers a shock-induced psychiatric illness as a result, then certain groups of people can claim damages, if their proximity to the event or people involved is close enough.

Firstly, certain groups of people always have their claims recognised. These include persons with a tie of love and affection to the primary victim, some bystanders (though the law applies the old test — the event must be likely to traumatis e almost anyone), and rescuers (although the law seems to relate to the damages being paid by the negligent defendant, not the rescuers’ employer). Some involuntary participants, for example those operating faulty machinery which harms another, may also be able to claim.

Secondly, proximity to the event must also be close enough in both time and space. The Law Commission suggests that the plaintiff must be either at the event, or perceive the immediate aftermath of the incident.

The final aspect of proximity is the means by which the shock was caused. The law is not totally clear on the necessity for the event, or its immediate aftermath, to be seen or heard by the plaintiff’s unaided senses, although this appears to be the requirement established by McCloughlin vs O’Brian.

The law can only deal with traumat a of human making, and where an individual or company can be found responsible. If the trauma is a natural disaster, there is no defendant and no legal recompense (Law Commission, 1995).
2.3.2 Employers' duties under the Health and Safety at Work etc. Act 1974

There is no legislative provision to deal specifically with psychiatric illness/nervous shock. However, the statutory duties laid down in the Health and Safety at Work etc. Act 1974\(^1\) apply to both the physical and psychological well-being of employees. A full review of the Act is beyond the remit of this study. However, the key requirement of the Act is that employers must ensure so far as is reasonably practicable the health, safety and welfare at work of their employees (Section 2(1) of the HSW Act, IRB Bulletin, 1995a). This duty covers both the physical and psychological health of employees — there is no justification for regarding physical and psychological injury as different kinds of injury.

Additionally, the Management of Health and Safety at Work (MHSW) regulations (1992)\(^2\) place a statutory duty on employers to conduct risk assessments of their employees' work (ie not just their workplaces). This is to enable employers to identify hazards to health (both physical and psychological): who could be harmed, how often, and how? These contribute to the evaluation of the extent of risk so that appropriate preventive or protective measures can be put in place, or the hazard removed.

The full requirements of the MHSW regulations are available through the Approved Code of Practice and Guidance on the MHSW. Practical guidance on improving health and safety in organisations is also available from the HSE.\(^3\)

2.3.3 Conclusions

Rulings on nervous shock/psychiatric illness are made from common law and can therefore be viewed to some extent as being in a process of development and refinement.

Psychiatric illness as a result of physical injury is relatively common. Less common are cases often referred to as 'nervous shock' — essentially, psychiatric illness as a result of exposure to a trauma in the workplace.

The employer will owe a civil law duty of care to an employee who:

* fears for their own safety


acts as a rescuer, or
- fears causing injury to another.

If employees do not fall into these categories they risk being categorised as bystanders, and the employer will owe them no duty of care unless they can satisfy further tests of proximity:

- proximity to the incident in terms of time and place, or
- had close ties of love and affection with a victim.

In criminal law, Health and Safety at Work legislation (1974, 1992) applies to both the physical and psychological well-being of employees. Employers are required to ensure, so far as is reasonably practicable, the health, safety and welfare at work of their employees. This includes undertaking risk assessments of both physical and psychological hazards.

It is difficult to speculate on the nature of claims due to a paucity of evidence. However, it has been suggested that the current principles allow scope for personal injury claims for psychiatric illness as a result of not only one-off traumatic events (e.g. a bank raid), but also prolonged exposure to a more everyday occurrence (e.g. bullying) (Cooper and Earnshaw, 1996).

In February 1995, a furnishings firm was fined £2,500 following prosecution by the Health and Safety Executive. The case concerned an employee who, after witnessing a machinery accident, later suffered from PTSD after she returned to work on the same machinery.

Finally, organisations need to be aware that managers of victims also have reactions to incidents. In one case study, the two line managers not at the incident were the worst affected, with one having to be medically retired as a result, and the other enduring a long period of sickness absence.

2.4 Trauma in the workplace: is there a problem?

In some occupations, exposure to traumatic events may be inevitable, e.g., soldiers in combat. However, many other workers may be subjected to traumatic experiences with varying frequencies. Some occupations may be exposed to sequential but less individually devastating trauma, e.g., traffic police, accident and emergency workers.

Data on the prevalence of traumatic symptoms is patchy and may not reflect the whole picture.
Research suggests that traumatic incidents are not uncommon and can occur on a fairly regular basis. As many as 65 per cent of workplaces have recorded physical assaults on staff, with up to 85 per cent citing verbal abuse or staff harassment.

Source: Tehrani, 1995

A study of self-reported working conditions found that six per cent of males and eight per cent of females reported having been attacked in their current job.

Source: Self-Reported Working Conditions in 1995
HSE Books

2.4.1 Which industries have employees at risk?

Previous research has tended to focus on industries where traumatic incidents could be expected to occur with some frequency (see Rick et al., 1998, for a full description). In fact, all industries have employees at risk. Experiencing an injury/accident at work can occur in any job, as can witnessing such an event to a colleague, which could in turn lead to the experience of PTSD or other trauma symptoms. Hence, although it is possible to identify several occupational groups within the literature where some form of data on post-incident reactions is available, this by no means represents the sectors more at risk, simply those where research has been done in the past. Occupational groups with data available on post-incident reactions are as follows:

- military personnel
- transportation workers (railways, maritime, aviation, road transport)
- emergency service workers (ambulance, fire, police)
- the financial sector
- health care workers
- offshore oil and gas industry
- other industrial processes, and
- nuclear workers.

For a full review of prevalence of incidents and traumatic responses in different occupational groups, see Rick et al., 1998.

There is wide variation in the probability and severity of traumatic incidents across different occupational groups, which makes comparison virtually impossible.

Certain jobs have known and repeated traumatic events (for example in the financial sector, where the majority of incidents are bank raids, or across the pavement attacks). Other jobs may regularly involve exposure to a wide range of extreme events — for example those in the emergency services — and many jobs
will involve contact with the public — for example, the public sector and the health sector. In occupations such as these, staff may accept frequent threats, or even violence, as part of the job and not report incidents at their true frequency. However, research suggests that the majority of assaulted employees will display typical trauma reactions.

Other types of experience that can give rise to trauma symptoms apply to a wide range of different jobs.

The following two sections (2.5 and 2.6) are abridged excerpts from *Workplace Trauma and its Management: Review of the Literature*. They are presented here to illustrate the degree to which workplace incidents can result in trauma. Road traffic accidents (Section 2.5) and Raids (Section 2.6) have been selected as examples of incidents that could occur across a wide range of occupational settings.

### 2.5 Road traffic accidents

Road traffic accidents are likely to affect a large number of employers, although the effects are distributed over a wide range of occupations. The UK, despite dramatic reductions in annual fatalities over the last ten years, still records around one-quarter of a million injurious accidents per year, with around 4,000 fatalities. With a prevalence such as this, it is no surprise that a substantial number of PTSD cases have been identified in association with such incidents, and that road traffic accidents represent large potential for incident-related trauma for both general and working populations. It has been suggested that motor vehicle accidents represent ‘the most adverse combination of frequency and impact’ (Norris, 1992, p. 409).

Mayou *et al.* (1993) reported a three and 12 month follow-up study of 188 road accident victims. They reported that at three-month assessment, emotional distress was ‘usually of moderate intensity’, although 41 per cent of the sample reported above threshold scores on depression and anxiety. Overall, Mayou *et al.* (1993) report that 37 cases (21 per cent) described significant psychiatric problems after one year. In terms of PTSD diagnoses, eight cases (four per cent) suffered PTSD at three and 12 months, five cases (three per cent) at three months only, and six cases (three per cent) at 12 months only.

Similarly, Blanchard *et al.* (1995) interviewed 158 motor vehicle accident victims one to four months post-accident, using standardised structured interviews to assess PTSD. They found that:

- 39 per cent met DSM-III-R PTSD criteria
- 29 per cent showed partial symptoms
- 32 per cent seemed ‘relatively unscathed psychologically’.

*From Accidents to Assaults*
The three groups were tested with work-related activities and Blanchard found that those diagnosed with PTSD performed significantly worse than either of the other groups, and a control group who had not been involved in motor vehicle accidents.

There were also significant effects on participants in terms of driving avoidance and phobia. Half of the PTSD sufferers who still drove avoided all discretionary travel.

Road traffic accidents are likely to affect all employees, not just the professional drivers identified earlier. The percentage of motor vehicle accident victims who go on to develop psychological problems is quite high when compared to the incidence in some occupational groups.

2.6 Armed raids/violent thefts

The data reported in this section relates to the financial sector. However, much of what is said could be applied to any retail or money handling setting.

It is comparatively recently that attention has turned to the prevalence and management of post-incident reactions in the financial sector. For the main part, this research has focused on the effects on employees of raids and hold-ups inside premises. Other incidents include 'across the pavement' attacks, hijacking or hostage taking, and the traumatisation of managers, colleagues or family. The details held on bank raids allow 'risk rates' to be calculated (ie hold-ups per branch). In 1993 there were 8,252 registered bank robberies in Europe — a risk rate of one raid per 24 branches (Kleber and van der Velden, 1996). Figures from the Banking, Insurance and Finance Union (BIFU) for the UK in 1991, suggested there were as many as seven office raids every working day.

Hodgkinson and Joseph (1995) measured the responses of 228 female bank staff following armed raids. They found that three weeks later, average scores on a measure of general health (GHQ) were well above the cut-off point indicating risk of psychiatric disorder. At the three month stage (following psychological debriefing which is discussed in Chapter 6), the mean scores had returned below the threshold, indicating that the majority of respondents had returned to their usual levels of psychological functioning. The study does not report on the numbers of those affected. However, their findings showed that different types of symptoms were more important at different times following the incident. Symptoms associated with intrusion and replicates (thinking about events when you didn’t mean to, other events being reminders of the situation) were predominant in accounting for the variation in symptom reporting at the three week stage, whereas three months later, items associated with avoidance explained more of the pattern of symptom reporting.
Research into traumatic events in financial services shows that levels of risk can change rapidly over time, and employers need to monitor some crime statistics to stay abreast of the true level of potential risk. Also, attempts to prevent one type of incident (eg raids) may generate a more extreme response (eg hostage-taking) from perpetrators.

In respect of the likelihood of developing a traumatic reaction, the evidence is not very clear, but figures of ten to 30 per cent have been reported. The research of Hodgkinson and Joseph also raises the possibility that for armed raid trauma, certain symptoms may appear in a particular sequence.

2.7 Experience of PTSD and traumatic symptoms

Current definitions of PTSD place greater emphasis on the way individuals react to situations (ie ‘the person’s response involved intense fear, helplessness, or horror in experiencing directly or hearing about a threat to another person’, APA, 1994). This development has possibly the biggest implications for the management of PTSD. As a result of this change it has been suggested that there will be a far higher rate of diagnosis for PTSD than previously, as diagnosis will be based more on symptoms than on the need for an individual to experience a threat directly.

For those who are responsible for management of post-incident reactions, this might be an acceptable and pragmatic situation, as regardless of actual diagnosis those experiencing trauma symptoms will be in need of assistance and support. On the other hand, it makes the parameters when planning such management intervention far less distinct, particularly with regard to who should receive trauma support services and how they should be made available.

Not all those involved in a raid or other traumatic incident will necessarily suffer psychological trauma as a result. In an overview of empirical studies into the outcomes of extreme events, Brom, Kleber and Witztum (1991) found that typically between 18 and 20 per cent of all people who go through extremely distressing events were left with permanent coping disorders associated with PTSD. In addition, those who did not develop PTSD were not necessarily free of other symptoms caused by the trauma.

A final but important aspect of experiencing trauma, regardless of the type of incident, are situations where a criminal or security investigation follows. This is often termed ‘secondary victimisation’ (Kleber and van der Velden, 1996) and refers to additional feelings of guilt and being under suspicion, experienced by victims who are not accurately informed about police and/or security processes.
The implications for organisations wishing to manage post-incident reactions are considerable as they suggest that what are routine aspects of the job, as well as major events, can give rise to the experience of PTSD or trauma symptoms in certain occupations.

Organisations should be concerned with the experience of traumatic symptoms (and the extent to which this affects an individual’s well-being and their ability to perform their job) if they are to manage situations effectively, rather than focusing solely on cases of PTSD.

This emphasises the need for employers to give careful consideration to the threats that exist within their workplace and to undertake thorough risk assessment in relation to psychological as well as physical factors.
3. Identifying Staff at Risk of Exposure to Traumatic Incidents in the Workplace

Key points

- Identifying employees who may be at risk of exposure to traumatic incidents in the workplace is part of an organisation’s responsibility to assess risk for psychosocial hazards.

- Unlike assessment of physical hazards where the harm caused is more likely to be direct and objectively measurable, assessment for traumatic incidents is complicated by a number of issues including, for example, individual differences in response to the same degree of exposure.

- As a result, assessment for traumatic incidents needs to build up a picture based on different sources of information about:
  - the hazards themselves
  - the evidence that they cause harm, and
  - the management procedures already in place.

- Risk assessment for traumatic incidents was less apparent than for physical hazards in the case study organisations visited. However, several had, or were in the process of developing, procedures for more accurate monitoring and assessment.

- The risk from hazards will vary from workplace to workplace and their potential for causing harm will vary from person to person. This makes it difficult to produce a comprehensive list of potential hazards that should be assessed for. However, there is a degree of consensus over types of work that need to be considered.

- Most importantly, organisations need to consider the methods they have available to them in conducting risk assessment.

Identifying psychosocial hazards

A hazard is something which has the potential to cause harm. Physical hazards, such as chemicals, dangerous equipment or excessive noise, can fairly easily be monitored, and their effects and associated health risks more directly observed. For example, the presence of a particular chemical in the workplace is relatively easy to monitor; likewise, a specific health complaint among those employees exposed to the chemical may be readily identifiable.

In the case of psychosocial hazards, which are those hazards which have the potential to cause psychological harm or physical harm indirectly through trauma-induced illness, assessment is far from straightforward.

Source: Cox and Griffiths
The main distinction usually drawn between identifying traumatic incidents as opposed to physical hazards is that physical hazards have a more direct and easily measurable effect. In fact, this is not always the case: we only have to think of asbestos or RSI to see that for some cases physical hazards can only be identified through a careful process of monitoring cause and effect over a period of time.

It is exactly this process which can be used in the identification of psychosocial hazards or traumatic incidents in the workplace. The identification of work-based psychosocial hazards for trauma through risk assessment may pose some interesting challenges for other reasons:

- There is little reliable information on the type and nature of incidents that give rise to traumatic reactions. In fact they can range from obvious threats like an armed raid to more everyday occurrences like bullying.
- In addition, trauma is in part defined by the individual’s reaction to the direct experience of an event, or their reaction to hearing of an event affecting a loved one.
- Despite equal exposure, only a minority will go on to suffer traumatic symptoms (harm) beyond a normal reaction (Rick et al., 1998).
- The reliability of the monitoring of traumatic reactions is debatable.

Inevitably, for the majority of organisations, their only form of assessment is on the basis of previous major incidents, yet incidents do not equate to trauma reactions. Furthermore, given the limited monitoring of trauma reactions in relation to more minor incidents, it is unlikely that a true understanding of the risks within an organisation can be built up from this approach alone.

Little is known about the likelihood of suffering traumatic symptoms beyond the very broad generalisation in DSM-IV that incidents of human design, eg torture, tend to provoke a more extreme reaction. Hence, it is important for organisations to monitor the demands of different roles or jobs and the impact on individuals.

3.1 How should traumatic incidents be assessed?

Despite the apparent difficulties or challenges presented by risk assessment for traumatic incidents, many of the case study organisations visited had in place innovative approaches to assessing risk. Evidence from the case studies is presented in Section 3.2 onwards. In fact, such risk assessment need not pose major challenges. Good risk assessment requires three main ingredients:
• an analysis of the tasks an individual must undertake to fulfil their role within an organisation

• details of the control or safety systems already in place, and

• assessment of the extent to which existing procedures actually match up to the experience of doing the job, and the extent to which existing control methods are adequate in preventing or dealing with situations when they occur.

To assist in this, many good checklists of risk factors already exist and can be adapted to any individual employer’s needs. This section will explore the various approaches adopted by case study organisations and the information that is generally available to assist employers in risk assessment.

Within our sample, risk assessment for psychosocial hazards was much less apparent than for other workplace hazards overall. Where interventions were in place, to minimise the risk of potential hazards causing harm, these tended to focus on particular types of event and the control systems already in place.

The criterion for labelling any aspect of work as ‘hazardous’ is the demonstration, by reference to historical incidents or by logical deduction, that it carries the potential for harming employees exposed to it. The act of relating the appraisal of hazardous events to health outcomes is therefore an important feature of the assessment procedure. Articulate employees are often easily able to list the various problems associated with their work, but this listing on its own is an insufficient basis for the complete/exhaustive identification of psychosocial risk factors in the assessment of risk. Evidence of associated harm is also required. Furthermore, before recommendations on the need for additional control can be made, existing control strategies need to be audited and taken into account.

![Diagram]

Source: Cox and Griffiths Handbook of Work and Health Psychology (1996)

The figure above illustrates the main elements of risk assessment for psychosocial hazard (including exposure to traumatic incidents). It can be seen that both psychosocial risk factors and the associated health outcomes need to be understood in order to assess accurately the risks of a particular type of work. Once these have been established, the management controls that are in place can be reviewed to establish the extent to which they adequately match up to the identified risks. Only then can recommendations be made as to improvements in job design, working practice or control procedures that will reduce risk factors in the job.
3.2 Risk assessment in the financial sector

Of course, some types of incident are obvious targets for assessment. In the financial sector, aided by the Banking Insurance and Finance Union (BIFU), bank raids have become a focus of risk assessment activity.

Figures on the frequency of raids is available from a number of sources. On a global scale, figures for 1993 for all industrialised countries indicated an overall risk rate (ie branches divided by hold-ups) of 1:19 over the preceding 12 months, with the total for Europe in 1993 being 8,252 registered bank robberies – a risk rate of 1:24 (Kleber and van der Velden, 1996).

The Banking, Insurance and Finance Union (BIFU, 1991a) published guidelines on aftercare and post-raid counselling in 1991. Their figures indicated that the number of raids on banks and building societies had nearly doubled in the four years up to 1991, and that at the time of their report, there were up to seven office raids every day throughout Great Britain. The total number of attacks in 1990 was estimated at 1,060.

However, the extent to which this hazard causes harm to individual employees is less well recorded.

It is in the financial sector where some of the most detailed and sophisticated risk assessment takes place, and in certain occupations security procedures will dictate the risk assessment process. As one security adviser commented:

‘The big risk for us is bank raids; almost every working day there is some kind of security incident. The management of these incidents is partly a security issue, but also an important one in occupational health terms. We’ve undertaken various measures over the years to assess and limit the risk.’

Risk at the Woolwich

An example of the implications for an individual organisation can be gauged from figures published by the former Woolwich Building Society. Figures for the two years to the end of 1995 revealed that 420 members of staff had been affected by robberies, burglaries and assaults (out of 4,100 staff in 420 branches), ie ten per cent of staff over two years. However, these are not diagnosed cases of PTSD, and many staff could have suffered from trauma reactions, ranging from minor shock to PTSD. This assessment also suggested that incidents were becoming more violent, and that with improved security systems incidents such as hostage taking appeared to be occurring more frequently.


All banks and building societies have an information exchange; there is no competition in terms of security. For that reason, the evidence presented in this section combines evidence on risk assessment from all the financial sector case study organisations.
Security standards have evolved over many years and are based on protection of staff, customers and money, in that order.

Risk assessment forms a large part of the role of security advisers using a matrix approach (conducted at a regional level). The type of information collected includes:

- firearm and crime statistics from every police force in the country
- historical data on the number of raids within regions and at particular branches
- the position of the branch (eg shopping mall versus bypass location)
- the number of staff employed
- the physical layout (eg distance from door to counter)
- the level of physical protection at the premises (eg type of screens etc.), and
- the level of physical deterrent (eg CCTV etc.).

By gathering this information, the security advisers are able to formulate an understanding of the branches most and least at risk, and focus the security budget accordingly.

The security adviser also has an important management and risk assessment role in the immediate aftermath of a raid. They have a police liaison role, which is intended to relieve staff of the burden of dealing with questioning that is not directly related to the incident (eg detailing normal security procedures, checking premises with police, dealing with video evidence etc.).

However, security advisers also need to make a careful assessment of how well security systems have worked or not. This can be a difficult business as it usually involves dealing with shocked and vulnerable colleagues who may feel that they are coming under suspicion or being questioned in a way that implies their responsibility for acting incorrectly in an incident.

'The average raid lasts 45 seconds to one minute — the impression among staff is that raids last five to ten minutes. We have to recognise that we are asking staff to make instantaneous decisions. There is no blame culture; it is important that staff feel whatever they did isn’t wrong. It might say in the formal report that official advice wasn’t followed, but no blame is attached.'

One security adviser summarised his role post-incident as follows:

1. Give feedback and reassurance that people did the right thing, check and feed back that the alarms worked, that the glass and building are secure etc., and highlight the positives to staff. Final report goes to ‘those who need to know’.
2. Check for breaches of security procedures.

3. Undertake a physical damage assessment or upgrade of equipment, if necessary.

4. Ask/identify what lessons there are to be learned, to take forward within the organisation (notify colleagues in security, alert head office, possibly put in a circular etc.).

The emphasis is always on trying to use an incident as a learning experience and circulate findings to other offices. The outcomes from this further assessment can have a number of implications or provide invaluable knowledge in improving the systems that already exist, eg changing the specification of a piece of equipment, or enhancing the physical security measures already in place.

Together with the Post Office’s Occupational Health Service Department, Cashco (a constituent business of the Post Office responsible for transporting money) started developing a trauma management response in 1992. Their particular concern was the increase in hostage taking that they had observed in similar commercial companies. Risk analysis revealed that attacks fell into four categories (in order of likelihood of occurrence):

• ‘across the pavement’ attacks
• hijacking
• traumatisation of managers, colleagues or family, and
• hostage taking.

Other parts of the business (eg the subscription services business which administers and enforces the TV licence system, including employees who visit houses where there is no record of a licence) found that the most severe attacks on individual staff occurred on the street or inside property.


Although bank or building society raids are the most frequently cited examples, risk assessment by security personnel in our case study organisations also focused on staff safety in the following ways:

• approving the design and layout of new or refurbished premises (property and plans)
• branch visits and assessments, and
• staff education.

In one financial sector organisation visited, the health and safety monitoring and controls, which contributed to the risk management framework, clearly specified robbery and Post-Traumatic Stress Disorder analysis.
In addition to raids, there are other smaller scale traumatic incidents to which employees in certain parts of the finance sector risk exposure in the course of their work. Such incidents include violence, defined by the HSE as:

"Any incident in which an employee is abused, threatened or assaulted by a member of the public in circumstances arising out of the course of his or her employment."

Sometimes the true risk of violence is difficult to ascertain. This was the experience at the Post Office’s Subscription Services business, as a high level of verbal abuse was seen as part of the job.

Source: IRS Employment Trends, 567 (1994) Violence to Staff, IND (C) 691

In 1996, HSE amended its definition to ‘any incident in which a person is abused, threatened or assaulted in circumstances relating to their work’.

3.3 Risk assessment in the public sector

One of the case study organisations in this sector was, at the time of interview, in the process of revising their guidance and reporting arrangements. Their experiences illustrate some of the important considerations for organisations when contemplating the monitoring of statistics. The organisation in question had originally been using the reporting systems required by law, i.e. head office held figures on three or more days absence, with more detailed figures held at a local level, but which were not easy to access or collate. The organisation recognised that this did not provide them with a sensitive enough measure for assessing different types of risk within the organisation so they had a drive to encourage staff to report incidents at work. They found that 99 per cent of incidents involved no absence, so absence figures, however recorded, could only indicate the tip of the iceberg when it came to understanding the demands of the job and the situations faced by employees on a daily basis.

Consequently, they revised guidance and reporting arrangements to reflect the experience of employees. Reporting of incidents is divided into three categories:

- verbal abuse (and threats)
- threatened assault (attempt made, but fails), and
- actual assault (i.e. physical contact between the assailant and the victim).

Of the actual assaults reported each year, 95 per cent involve no injury or absence from work. The average office will experience

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1 The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR ’95).
four incidents a year, of which three will be verbal. Although the overall risk of serious incidents is low, this system allows the organisation to understand where there might be particular problems and target resources appropriately.

Analysis of national trends has also provided pragmatic advice on, for example, timings of appointments for different customer groups in order to reduce the likelihood of incidents.

In addition to the national reporting, the organisation is currently in the process of undertaking an audit of safety management systems in all offices. Incident report forms provide information on what happened, and guidance can be provided to offices on an individual basis.

It is important that reporting or monitoring systems provide a true reflection of experiences in the workplace if organisations are to understand and effectively manage risk.

3.4 Risk assessment in the emergency services

Risk assessment in the emergency service organisations taking part in this research tended to be around major incident planning, or workplace and equipment. There was little evidence of formal risk assessment for psychosocial hazards. However, there was much awareness informally among staff of the particular role or types of incident that were particularly challenging.

In the fire and rescue organisations studied, a range of incidents were easily identified:

- any incident involving children
- large/multiple road traffic accidents (RTAs)
- a fatality at an RTA, in particular a mutilated body or a death at the scene
- the collapse of a building or trench, particularly where rescuers have contact with the casualty, or where there is a death in the process
- fires involving multiple deaths, especially family groups
- crews with several young or inexperienced firefighters.

In addition to established causes such as these, the managers (ie sub-officers or leading firefighters) spoken to in the course of the research identified situations which might not be extreme, but which an individual could ‘hook into’ on a personal level (examples of situations that employees could easily identify with included dealing with children of similar ages to their own, dealing with an incident involving the same make, model and colour of car as a family member [ie an ‘is it them?’ experience]). However, there was less evidence of psychological harm as a result of these incidents. In part, this was felt to be due to the
‘macho’ organisational culture which did not support admitting to feelings of distress because they were seen as a weakness.

An ambulance service visited had commissioned research to examine risk to employees, which took a holistic approach to the health, safety and welfare of staff.

While there is no written policy on trauma management available within the Trust, the approach taken to managing potentially traumatic situations, including preventative strategies, is outlined in the Business Plan. Of particular relevance are the key objectives for the Trust laid down in the Business Plan, some of which are to:

- explore opportunities for developing and implementing peer group support across a range of subject areas
- establish a Clinical Risk Management Near Miss reporting procedure that will enable the Trust to identify within 24 hours any risk that presents the potential of a negligent claim, thus giving the opportunity to address the issues raised appropriately
- develop risk and quality standards, and feedback loops, to encourage all employees to express concerns, and offer constructive comment for future development
- expand the current health and safety team to encompass risk management responsible for risk assessment and risk minimisation
- establish with insurers and the Trust, programmes of recognition and rewards, in areas such as safe driving and work practices
- work with the Emergency Planning Officer to ensure an Internal Disaster Plan, acceptable to insurers and the Trust, is in place, and develop managers and staff to enable them to plan for prevention of catastrophic events
- ensure that the philosophy of risk, and health and safety management, remains top of everyone’s agenda and that principles of risk management are integral to all activities
- reinforce external networks
- improve consultation and involvement of staff in health promotion
- implement research programme into organisational stressors and develop staff support systems appropriate to the needs of the Trust.

In terms of evaluation of initiatives, the Business Plan is used to monitor progress and measure performance of the Trust. Ownership of the Business Plan is strongly encouraged for everyone within the Trust to facilitate the teamwork needed to meet the mission statement of the Trust.
3.5 Risk assessment in the health sector

Within the NHS Trusts visited for this research, there was more variation in the nature of risk assessment in relation to particular jobs. In one trust, jobs more ‘at risk’ were not formally recognised at a corporate level, but among the staff interviewed there appeared to be recognition and clear consensus that some areas of work were particularly challenging:

- A&E (Accident and Emergency)
- Intensive Trauma Units (ITUs)
- child health
- coronary care
- secure psychiatric units, and
- any job involving a lone worker role.

As a result, risk assessment took place at a local level, but the need for such activity was not acknowledged on a wider scale within the organisation.

3.6 Techniques for assessing risk of exposure to trauma

Where risk assessment procedures are not in place, assistance in the form of guidance is available from research work in other more well established areas, such as violence. For example, the types of different work which might expose people to violence are presented in the box below.

<table>
<thead>
<tr>
<th>Broad guidance is available in this area from sources such as the TUC, which has identified the range of workers who are particularly at risk from violence. These include people who:</th>
</tr>
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<tbody>
<tr>
<td>• provide care, information and advice</td>
</tr>
<tr>
<td>• handle money or valuables</td>
</tr>
<tr>
<td>• inspect and enforce laws</td>
</tr>
<tr>
<td>• work with potentially violent people</td>
</tr>
<tr>
<td>• work in isolation, or</td>
</tr>
<tr>
<td>• work in public services/have contact with the public.</td>
</tr>
</tbody>
</table>

Within any organisational setting, such broad pointers can be a start to identifying any jobs where employees might be at particular risk.

More detailed guidance is available in relation to specific occupational sectors. HSE has published comprehensive guidance on assessment and management of violence towards staff in health services. This identifies the following factors as having the potential to increase the risk of violence in certain settings:

(cont’d)
• working alone
• working after normal hours
• working and travelling in the community
• handling valuables or medication
• providing or withholding a service
• exercising authority
• working with people who are emotionally or mentally unstable
• working with people who are under the influence of drink or drugs
• working with people under stress.

While these risk factors have been developed with the Health Services in mind, it is clear that many will be relevant to a wide range of other occupations.

Source: Violence and Aggression to Staff in Health Services, HSE Books

Rather than a particular type of work, there may be one or two small aspects of the way a person is required to do their job that puts them at risk. Because the job itself is not regarded as 'high risk', the danger is that there can be lack of recognition that certain tasks put people at risk.

UNISON (the biggest health services union) has been promoting risk assessments since May 1997 and has produced a violence risk assessment checklist.

Jobs
1. Do employees work with the public?
2. Are employees required to wear name badges?
3. Are site/home visits made?
4. Do any jobs involve lone working?
5. Do any jobs involve working unusual hours?

Work environment
1. Do interviewing rooms offer a means of easy retreat?
2. Are there sufficient and suitable alarm systems?
3. Are reception/waiting area facilities designed to provide comfort and security?
4. Are car parks and areas surrounding the premises well lit?

Work systems
1. Are staffing levels appropriate for the needs of the service?
2. Are staff trained and instructed in violent incident procedures?
3. Are procedures in place to report and record incidents?

Source: UNISON
Some techniques for assessing or measuring psychosocial hazards

Desk research: The importance of desk research is often underestimated when assessing psychosocial hazards. However, very important aspects of hazards can be identified using a number of sources of information. First are the organisation’s policies and practices:

- Look at records of incidents: can you be sure that these reflect the true situation?
- How complete is the recording system? Does it include non-injury incidents? Does it provide information to allow investigation and follow-up?

In the case of assessing whether or not career progression might be a hazard, a number of questions about policies and practices can be asked, such as: Does the organisation have clear promotion policies? Do these appear to be fair? Are they applied in practice? Are employees offered training and development opportunities? How do these compare to other organisations? Other potential hazards can also be assessed in this way including work schedules and some aspects of organisational culture. In other words, it may be possible simply by examining written policies and practices to get some idea of potential hazards.

Qualitative techniques: Talking to local managers, employees and their representatives is a useful way of identifying what actually happens in the workplace and whether that matches up to policies and procedures in place. Are policies and practices realistic and workable?


One of our expert interviewees characterised several cases of chronic trauma they had seen (ie acute trauma lasting for longer than a year) as individuals being recruited to a job, being promoted, not being trained adequately, being criticised for not being able to cope, and subsequently being worn down (which in the case of a specific incident could give rise to more severe trauma).

Thinking of who might be harmed is not necessarily as simple as identifying those involved in any incident. Many case study organisations identified a ‘ripple effect’ where, for example, the managers of those involved in an incident experienced traumatic symptoms and feelings of guilt/responsibility. Care needs to be taken to identify all groups of employees who might be affected.

Some techniques for assessing and measuring psychosocial harm

Desk research: As with the assessment of psychosocial hazards, desk research can play an important part of assessing psychosocial harm. While the feelings and thoughts associated with trauma cannot easily be assessed using desk research, many of the behaviours can be. For example, examining historical records of performance, absence and turnover and their recorded causes may, in themselves, reveal some important patterns of relationship. At the same time, such data can be used as a benchmark or baseline for evaluating future interventions.

(cont’d)
Self-report questionnaires: In terms of assessing employees’ feelings and thoughts, this technique is the most widely used. Measures of mood, physical symptoms, psychological symptoms, job (dis)satisfaction and self-esteem are widely available. While many commercial measures exist, these are not necessarily reliable or valid. It is probably preferable to use well-established measures that have been used for research purposes. While most of these measures are available in the public domain and their use is free, they are not as easy to obtain. Occupational psychologists and academic researchers should know and have access to such measures.

Qualitative techniques: As discussed above, these techniques are extremely useful for identifying the meanings of the thoughts and feelings which may be a consequence of hazards and also for identifying the processes which may account for the causal links observed. A group of employees may, for example, report low levels of commitment on a questionnaire, but in order to understand what this means to the people involved or how they believe this developed, interviews or focus groups may be required.


Evaluating the risks

Once the hazards and those who might be harmed have been identified, there is a need to check whether the precautions already in place are adequate. If they are not and significant risks remain, more will need to be done. The most serious risks should be considered, and those which affect the most people first.

The most effective precaution is to avoid risks altogether. This may not always be possible, in which case you need to consider the steps which can be taken to minimise the risk. In developing precautions, you may find it helpful to ask yourself the following questions:

- Is there any way to change:
  - the jobs people do?
  - the circumstances in which they work?
  - the way jobs are done?
  - the workplace?
  - the information given to employees and the way it is communicated?
  - the system for sharing information about potentially aggressive members of the public?
  - the response to incidents?
  - the incident recording system?

- Is training directed at the risk and the relevant employees? Are managers fully involved in the procedures, policy, responses and training?

- Are there support systems for employees which are confidential, accessible and do they lead to a return to work?

(cont’d)
Recording findings

The main findings of the risk assessment must be recorded. These may include:

- the hazards identified, potential assailants and high risk areas
- the staff groups exposed to risks
- the existing preventive measures
- an evaluation of the remaining risks
- any additional preventive or control measures identified.

Aim to record the findings of your assessment in a way which provides a useful working document for managers, employees and their representatives. They will then understand what action they need to take and find it easier to decide when the assessment needs to be revised, or further preventive measures are necessary.

Source: HSE (1997), Violence and Aggression to Staff in Health Services
IES (1998), Expert Interviews

3.7 Conclusions

- Risk assessment of traumatic incidents varied considerably across the case study organisations as a group.
- Assessments for the main part tended to focus on numbers of incidents such as bank raids and violent customers. While this may prove a useful starting point it is important that organisations assess the extent to which harm emanates from such incidents. They also need to give consideration to the more mundane, everyday occurrences that can lead to trauma symptoms, e.g. bullying.
- Additionally, there was little evidence of assessing for psychosocial harm as a result of a physical hazard or incident. For example, victims of, and witnesses to, an accident at work can suffer traumatic symptoms as a consequence.
- Monitoring of health statistics often focuses on diagnosed PTSD. Yet the available evidence suggests that only a small minority of individuals will develop PTSD. A far more significant number are likely to suffer from trauma symptoms which could well prove distressing and have a serious impact on their ability to perform their work.
- In sectors where risk assessment for psychosocial hazards is not in evidence, there appears to be a degree of consensus about the roles that involve particular challenges. General information and checklists, such as the examples given here, are also available where monitoring and risk assessment procedures are not fully established.
4. Pre-Incident Activities

Key points

Case study organisations demonstrated a variety of different approaches to minimising the risk of traumatic incidents at work. These included selection and recruitment procedures that ensured applicants had a clear idea of the demands of the job they were applying for, and ensuring teams have the right skill mix.

- Thorough risk assessment can identify jobs where there are specific risks or skill needs. These can then be dealt with through appropriate training or job redesign.
- Other forms of training and preparation fell into four broad areas. On the preventative side, there was fairly widespread use of security measures, such as CCTV, as well as training in preventing incidents from occurring. Other pre-incident activities involved training in how to respond to incidents (e.g., bank raid drills) and education on the potential reactions to a traumatic incident and the support that was in place.

In determining how much action to take prior to an incident, organisations may find themselves having to tread a difficult line between, for example, introducing realistic security precautions without overly inhibiting staff in performing the jobs they are employed to do. Equally, it can prove a difficult balance between educating staff and preparing them for what to expect, but not over sensitising them, or provoking anxiety about extreme situations that have only a small likelihood of occurring.

It is hardly surprising then, that evidence from case study organisations revealed a wide range of pre-incident activities with differing aims. These activities varied from selection and recruitment processes, to critical incident plans and the structures in place to assist individuals, should an incident occur.

For the main part, efforts were focused on preparations for dealing with an incident. However, there were a few examples of selection and recruitment practices aimed at ensuring that job applicants had a clear understanding of what the job they were applying for would involve.

4.1 Selection and recruitment

Input to selection and recruitment practices is perhaps most appropriate for applicants to the emergency services, where
personnel can be exposed to unpleasant, challenging or tragic incidents on an everyday basis. This was certainly the case in the fire and rescue services involved in this research.

**Evidence from case study organisations**

In the first example, the brigade invite ‘would be’ applicants to an assessment seminar. In an environment where applicants outnumber job vacancies many times over, the purpose of the seminar is to ensure that those wishing to put in an application have a clear understanding of what exactly firefighter work involves. Occupational health and safety have an input into these seminars to raise awareness among applicants about the psychological as well as the physical demands involved in the work. Those still wishing to apply are given the appropriate forms at the end of the seminar. Following ability, physical fitness tests and a medical, those who are made a job offer will also undergo an awareness raising event (outlined in brigade orders) as part of their induction. This event covers critical incidents and possible reactions as well as the support and structures that are in place for firefighters, should they be required.

In the second example, efforts have focused on alerting fire and rescue trainees, and raising their awareness so that they are prepared for the situations they might have to face.

**Evidence from case study organisations**

During the 16 week initial training, there is input from the occupational health department on the nature of incidents and the possible psychological reactions. This brigade is also currently compiling a video from the accidents that they attend. The intention is to use video footage over the length of the training course, starting from the scene as the tender arrives and building up over the 16 weeks to a working idea of what to expect on a call out.

In both examples the emphasis is clearly on ensuring that those who apply to the fire service have a clear idea of the work that they will be required to do, and can as far as possible self-select, rather than risk trainees coming in only to leave fairly quickly, or even worse be traumatised by their experiences. Although this can mean slightly higher drop-out from training, or fewer applicants, it is seen as highly beneficial in the longer term to all the individuals concerned and to the fire brigades involved.

**4.1.1 Selection for specific jobs**

Aside from general recruitment strategies, there was also some evidence of organisations focusing on recruitment or promotion into certain roles which were perceived to be more ‘at risk’.

It has to be said that the need to recognise the demands of different jobs tended to occur at a local level. With a few notable exceptions, there was often little ‘corporate’ recognition of jobs which might carry a particular risk. This flew in the face of
consensus within organisations where staff interviewed had no difficulty in recognising which jobs these might be and why they would carry additional hazards.

**Evidence from case study organisations**

Examples here included selection for work in an accident and emergency department where, in addition to general medical skills, it was recognised that staff needed excellent interpersonal skills and the ability to work quickly and efficiently in high pressure conditions. In particular, skills for dealing with difficult patients and for defusing violent/aggressive situations were tested at interview. Other policies here included selecting on the basis of the teams’ skill mix to ensure that the department maintained a wide skill base. In part as a result of this policy (introduced at a local level), the team has seen increased morale and commitment to the work, and a greater sense of achievement as a team.

In a separate example, a 24 hour retail outlet has been developing selection skills to ensure that those taken on are suitable for lone worker roles and night work. As a result of this and other measures, they have seen a drop in staff turnover from 50 to 35 per cent.

It is clear that in certain settings, trauma management policies can make a major contribution to selection and recruitment processes, thus ensuring that recruits have the requisite skills to deal with the demands placed on them in certain jobs. Employers need to pay particular attention to detailed task analysis for individual roles, as outlined in the previous chapter and below, in training and preparation.

### 4.2 Training and preparation

Selection for specific roles is likely to have only a limited application. In many instances, training or preparation of personnel has a more important role to play in minimising the risk of incidents occurring, and of minimising the psychological consequences of such incidents.

Many examples of incident training or preparation, as well as guidance, were found in our case study organisations. This training and/or preparation related to a wide variety of different work settings.

The extent to which detailed guidance can be given depends upon the extent to which an incident is 'knowable' or reasonably foreseeable, which in turn depends on thorough risk assessment (see previous chapter). As a result, the evidence presented in this section can be broadly categorised into the following four areas:

- security measures and practices in place to minimise the likelihood of incidents
- training or guidance to help staff prevent incidents from occurring
• training or guidance on what to do when an incident occurs, and

• information and education on the likely consequences of an incident, and the support and help that is available if required.

The first two of these aspects of prevention are considered in the sections that follow.

4.3 Security measures and practices

4.3.1 Financial sector

Much of the identified risk in organisations can be minimised by security procedures. Within the financial sector the main risk is that of raids on branches, and there is much emphasis in minimising risk through security procedures. The financial organisations participating in this research covered the following practices:

• closed circuit television in branches (usually advertised to customers with monitors visible in public areas)

• strict till limits

• timelocked tills (advertised)

• counter screens, and

• interlocked lobbies.

In addition to these physical security features, many financial organisations encouraged other practices, such as dissuading customers from wearing crash helmets in branches. Other procedures exist for staff in relation to locking systems and keyholders for opening and closing premises.

Evidence from case study organisations

The financial sector organisations have also identified interesting findings in the way that business developments and practices have had an impact on the likelihood of raids. The range of services offered by banks has changed dramatically in recent years. Whereas previously people came in, got money and left, now they might be in a branch for any amount of time depending on the reason for their appointment (eg for a mortgage etc.).

As a result, people tend to be in the branch for much longer and it is more difficult for a potential raider to judge if the bank is empty or not.

Financial sector organisation have also discovered that having staff in public space has made a difference, as has increasing the amount of public space within a branch. When the public space is larger it becomes harder to control, and with staff in the public areas raiders may have to turn their backs on staff, which they don't like.
As a result, financial sector organisations have seen a clear drop in the number of raids proportionally in their more open plan branches.

As businesses change or services develop, or even simply as the demand for certain services increases, so the security needs must be continually monitored and adapted appropriately.

The William Hill Group

This organisation runs a chain of 1,540 licensed betting offices, and cash is the main commodity. William Hill identify their main threat of violence to staff as robbery. As a result they have introduced a number of preventative measures. These include:

- safe inserts that can only be opened at specific times (and are advertised as such)
- guidelines on keeping cash levels to a minimum, and
- advice to staff on taking different routes and on what to watch out for when banking cash.

Targeting through risk assessment

Thorough risk assessment enabled William Hill to identify certain types of office where robberies or violence were much more frequent. Using this information, it installed CCTV in about a fifth of its branches, with the result that robberies were reduced by almost 80 per cent.

Developing security with a changing business

As the business has developed and changed, so the preventative measures in place have been adapted appropriately. For example:

- personal alarms were issued to all staff when betting offices commenced evening opening, and
- ‘steaming’, the trend for gang thefts which originated in America, meant that William Hill needed to reverse its policy on no screens in betting shops. New screens which were designed to be more customer friendly were installed in the metropolitan London area (within M25). In addition, all new shops and refurbishments are considered on an individual basis to assess the need for screens.

Source: IDS Study No. 628 June 1997, Violence at Work

Many examples of security measures or practices aimed at prevention of incidents were found in other case study organisations, and these are discussed in turn.

4.3.2 The health sector

Several of the security measures highlighted above have now become a feature of life in the health sector as well. Personal alarms, security guards, screens in A&E departments, and CCTV,
have started to appear in many wards or whole trusts within the NHS. There are also certain aspects of health service work that have necessitated the development of other security measures as standard procedure.

**Evidence from case study organisations**

One of the health care organisations studied for this research has developed specific procedures for staff who need to visit mental health outpatients. As a matter of course, as much information about the patient as possible is collected prior to the meeting being arranged. With each patient, based on their psychiatric history, a decision will be made about who in the team will attend the meeting and the location of the meeting (e.g. the patient’s home, hospital or GP’s office).

At the time we visited this Trust, it used Health of the Nation Outcome Scales (HoNOS) with in-patients. This is a standardised form which collects ratings on the patient’s behaviour, psychiatric symptoms, personal circumstances and social networks to establish a full picture of the individual. It is planned to extend the use of HoNOS to outpatients, and it is foreseen that this will assist in the assessment procedures prior to visits.

In another of the trusts visited, an initiative to minimise the potential risk to control room staff has been to address their concerns about ambulance dispatch issues.

**Evidence from case study organisations**

The service operates standard dispatch protocols which have been generated by medical professionals to guide control room in their decision of what level of response to make to an emergency call. Control room staff are not required to make medical decisions. Rather, they ask a series of standard questions of callers to ascertain the medical status of any casualties. The responses given, alone, will inform the level of response given and the protocols also include information to be offered to callers to assist them in dealing with any casualties prior to the arrival of ambulance personnel. This practice serves to minimise the traumatic potential of 999 calls for control staff by ensuring they ‘go by the book’. All calls are monitored and ‘rogue’ calls are frequently used for training purposes. That is, control room staff receive a call which is not genuine but ‘actors’ play the roles of callers. Control room staff have to manage these calls according to the protocols given, no matter how bizarre the callers may act. The audio tapes of the interaction can then be reviewed and evaluated with respect to the standard protocols.

4.3.3 Other public sector organisations/jobs with high client contact/retail

Organisations where there is a high degree of client contact have also introduced many standard security based procedures and practices. Once again, security guards, CCTV, personal alarms, and secure areas, are common examples of such practice.
Evidence from case study organisations

In certain circumstances, however, the nature of the interaction with the public means that other options need to be considered. One case study organisation, with open plan offices, has developed a system of ‘wagon train’ desks (a link or chain of desks), providing a safe area for staff. In addition, if there is a risk of clients becoming violent, moveable objects such as computers are secured to desks.

4.3.4 Twenty-four hour retail sales

Evidence from case study organisations

Other case study organisations with customer contact through retail sales, in addition to the types of cash handling procedures described above, have opted for the following measures:

* secure areas for staff
* ensuring that premises are well lit and well staffed
* using night pay windows, and
* providing staff with a ‘carephone’ system (24 hour alarm system that can be carried in pocket, worn on wrist or round neck).

In addition, in extreme circumstances, organisations have amended opening hours to limit seasonal risks (eg shortening opening hours over the winter periods). In some circumstances it has been decided to re-situate shops and services to locations with a lower risk assessment.

4.3.5 A more proactive approach

A final safety measure that appears to have gained favour with a number of our case study organisations in the health, public and retail sectors over recent years has been to take a more proactive approach in dealing with the client or customer directly.

Evidence from case study organisations

More proactive measures include:

* issuing warning letters to customers whose behaviour is unacceptable
* commissioning solicitors letters to reinforce the message to customers whose behaviour is unacceptable
* encouraging the police to take action, including reporting for prosecution, and
* encouraging and supporting individual private prosecutions if necessary.

These standard measures are seen to be particularly valuable in establishing precisely the levels of conduct that are expected from customers and in supporting staff in the execution of their duties.
Clearly, this can be difficult in situations where, for example, it is a healthcare setting and a patient is confused or in great pain. However, the Patients’ Charter is addressing this, where appropriate, through re-defining acceptable behaviour and contracting with the patient about what is reasonable.

Brighton Healthcare NHS Trust

Brighton Healthcare NHS Trust employs around 3,500 people on four sites. The Trust has a full time security manager and has been developing a number of policies to cope with violence in the workplace. Analysis of reported incidents revealed 110 incidents for 1996. There has been a general increase in the number of reported incidents, although this could well be due to improved reporting procedures rather than an actual increase in incidents.

Most importantly for the Trust, no pattern of incidents could be established with regard to time. However, roughly half of the incidents were occurring in the A&E department and were perpetrated by patients or visitors.

Standard practices were introduced into the Trust in the form of CCTV and panic alarms (both fixed and hand held). In addition, the Trust uses security staff. As with several of our case study organisations, the Trust has also taken a proactive stance on the prosecution of individuals if necessary.

A final initiative undertaken by the Trust (and not identified in our case study organisations) has been to work with the local paper in raising public awareness of what Trust staff have to face on a day-to-day basis. In this way the Trust hopes to have some influence on the public perception of what they do.

Further provision for the security of staff has focused on what they are legally permitted to do in terms of restraint, as well as training in security, and training in handling aggressive or conflictual situations. These aspects of prevention are addressed in the next section.

Source: IDS Study 628, June 1997, Violence at Work

4.4 Preventing incidents from occurring

In this section the focus is on the skills and support provided to staff to enable them to prevent or contain a potentially traumatic incident from occurring or escalating.

Many examples of preventative action were in evidence among the case study organisations, and for the most part such interventions focused on what could be broadly termed ‘people handling skills’. People handling skills cover not simply the immediate actions, but also decisions about what action to take. The following examples represent a composite of many aspects of training existent in the case study organisations we studied.
4.4.1 Keeping records

Where contact with customers or patients is of a regular or ongoing nature, many organisations encourage the keeping of records of all bad behaviour by customers or patients, including:

- verbal assault
- threat of physical assault
- physical assault, and
- intentional damage to property.

Similar reporting is strongly encouraged in cases of racial or sexual abuse, or other forms of harassment, from a customer or patient.

4.4.2 Avoiding confrontation

In deciding what action to take, the individual is trained to consider:

- the immediacy and seriousness of the threat
- how often the customer or patient has displayed unacceptable behaviour in the past
- the individual's ability to understand the problems they are causing (bad or abusive language may be a normal method of communication).

Much of the training in customer handling or 'defusing' training (in this case, calming situations down) consists of a number of very similar core elements:

- information about how and why situations can escalate
- how to recognise the danger signs
- how to react to defuse situations (both verbal and non-verbal actions), and
- how to escape from conflict.

Several of our case study organisations were able to reinforce the use of these techniques, with evidence of increased confidence and morale among staff and reductions in the number of serious incidents. However, little of this information was recorded formally.
The Banking Insurance and Finance Union

The Banking Insurance and Finance Union has played a very active role in promoting information on the prevention of raids and the protection of staff. Among this guidance, it also issues specific guidelines for dealing with aggression, which apply to a wide variety of settings:

- stay calm and don’t argue
- don’t touch your aggressor
- avoid adopting a confrontational manner
- offer to talk about the problem
- avoid being alone in an aggressive situation
- do not remain alone with an apparently violent person, withdraw
- do not turn your back if retreating
- be aware of escape routes
- consider if you are the best person to deal with the client, and
- remember — aggression incites an aggressive response in ourselves: don’t get into an argument.

Source: BIFU, Safe to Go, 1991

4.4.3 Control and restraint

In some cases, simply calming situations down is not sufficient, and employees may need to restrain a customer or patient in order to contain a situation and prevent injury or damage. In one case study organisation dealing with patients with mental health difficulties, all staff undergo a one week control and restraint training course, and are required to attend a one day update or refresher course every six months. This is in addition to their professional training, which involves anticipating and averting difficult situations.

However good the security measures in place in an organisation, and however highly skilled the employees, for all the organisations in this research, there were times when incidents became critical, or traumatic events occurred in the workplace. Organisations prepare their staff as much as possible for such situations by both:

- training in how to respond to traumatic events, and
- education about the experience of such events and the support systems that are in place.

These two aspects of pre-incident activities are now explored more fully.
4.5 Training and guidance on what to do during an incident

Responses to the Delphi exercise (see Appendix 1)

Training and preparation

Evidence from the Delphi exercise suggested that many employees felt training or preparation was limited. The preparatory training that trauma survivors report is mostly in terms of procedures, which is essentially what organisations deem to be a necessary response to the management of risks. That is, assess the risk and develop procedures and countermeasures to address and eliminate those risks where possible. However, trauma survivors’ experiences point to limitations in this approach. Survivors point to the lack of training in preparing them for how they felt post-incident and how to cope in the aftermath. Also, the relevance of training was questioned and its inadequacy highlighted, specifically in incidents involving extreme violence and hostage taking.

‘There is no training like having to do it for real.’

Training and guidance on what to do

Trauma managers do report receiving training at work that has proved helpful to them personally in post-incident management. While there are no reports of specific policies to guide managers’ actions, procedural training is common. This includes defusing, trauma briefing, Critical Incident Stress Debriefing (CISD) and discipline. The main problems appear to be in the understanding of what a critical incident debriefing is, specifically confusion between operational and psychological debriefs, and wide variations in practice. Also, one manager reported that the training he received was limited, covering most of the things learned previously by trial and error.

Information/education

Trauma survivors found that information from within the organisation was generally not helpful for trauma survivors post-incident, save for knowledge about crisis management teams which had been set up within an organisation which can take over the work of the employees affected by incidents.

However, trauma survivors do appear to have some life experiences, knowledge or information which they found helpful post-incident which suggests potential coping resources which could be mobilised. Themes emerging from survivors’ responses included prior knowledge of a system of social support, anticipating coping strategies, repeatedly experiencing incidents leading to reduced anxiety which facilitated managing the event, and a previous life-threatening illness which led to the development of a logical approach to problems.

The information/knowledge that trauma managers gained from the experience of managing is indicative of what we know from the literature — that the learning experience can either be adaptive or maladaptive. Adaptive learning enables managers to anticipate future incidents with confidence, be mindful of the pitfalls or to habituate to events in which very little is of surprise or troubling; or maladaptive learning, with managers being unhappy at the prospect of having to deal with incidents in the future.
Virtually all the organisations participating in this research have clear guidance for staff on what to do in the event of a traumatic incident. Inevitably such guidance varies, based on the nature of the incident in question. For the most part, guidance stems from thorough risk assessment and targets, 'knowable' or predictable trauma. This is considered first.

### 4.6 Financial sector

For the financial sector organisations participating in this research, by far and away the main concern was that of raids on branches. As identified in the previous chapter on risk assessment, bank or building society raids for the most part follow a very similar pattern, and as a result detailed guidance for staff can be produced. Other (far less frequent) situations of concern relate to hostage taking and kidnapping situations, and far less 'knowable' events such as bomb threats. Even so, there was some variation in the extent to which case study organisations educated staff in general about the nature of traumatic incidents.

#### Evidence from case study organisations

In all examples from the financial sector, staff are trained in security procedures as part of their induction at a local level. Their knowledge and information is then updated on a regular basis and this work is supported by videos. Such training can involve detailed structured approaches to raids. The main message from such training is invariably that the safety of staff and customers is the top priority. As one manager put it:

> 'If there's one rule it's that we don't want heroes; either trigger the raising screens or stand back and let them take the money. My concern is with staff in the public area and whether or not they are going to have a go. We really drill it into them and make it absolutely clear that they must not tackle raiders.'

However, a conscious decision has been made in this organisation not to focus overly on raids and possible consequences. This is felt to be the right decision as the organisation does not want to run the risk of oversensitising staff to what remains a very minimal risk.

In another organisation, the pre-incident measures described below were initially met with a degree of scepticism, but are now very broadly welcomed.

#### Evidence from case study organisations

Other financial sector organisations have taken such pre-event training further, as this comment from a security adviser explains:

> 'We have maybe one fire in a branch every ten years, but still have fire drills all the time. At the time raid drills were started we were having between one and five raids a week, and staff had general instructions, but no practice. So we devised a series of raid drills that are carried out the same as a fire drill might be.'

(cont’d)
All staff have to participate and not miss the training. Trouble is taken to ensure that all staff (including part-time and jobshare staff) participate in these drills on a regular basis.

In addition to raid drills, 1993 saw the making of a bank raids video. This is an instructional video using staff volunteers. It uses employees’ own descriptions of their experiences, what they did at the time, as well as how they reacted, and subsequently got over the experience.

As a result, this organisation reports that employees are much more comfortable and confident about what they should do or not during a raid. The feeling is that this approach has helped to reduce raids and improve staff morale. The experience of this organisation is that when staff know that they have done something positive, even in a really challenging situation, they tend to get on top of it a lot better.

4.7 Major disaster plans

In some instances, guidance is in the form of a major disaster or critical incident plan (most notably in the health sector and emergency services) and policy statements of organisational response to traumatic incidents. This includes guidelines for staff, what will happen when, and who is responsible for delivery. The extent to which psychological welfare of staff is highlighted in such disaster plans can vary a great deal. Aside from the scale of event, one of the ways in which major incidents differ from, for example, bank raids is in the duration of the incident.

Evidence from case study organisations

In one example from an A&E department, efforts were aimed at helping staff to cope with particularly gruelling shifts, where for the duration of the shift they can be dealing with one critical incident after another. The practices in place involve:

- careful attention to off-duties and rotas, with breaks planned between shift patterns
- ensuring that there is a wide skill mix (including children’s nursing and mental health liaison) to ensure that they have the right skills in place to look after the patients that come in
- bringing in extra staff during recognised trouble spots (Friday and Saturday nights)
- rotating where staff work, so for example they won’t always be based in the resuscitation room
- ensuring that junior staff never work in the resuscitation room on their own, but are always supported (a mentoring system exists to ensure that this happens), and
- ensuring that staff take regular breaks during the shift.
Psychological well-being is also identified as a priority in the disaster planning in this organisation. This is discussed more fully in the next section.

Even where the psychological impact of an incident is not the priority, training can play an important part in preparing staff.

**Evidence from case study organisations**

One of our case study organisations, a major travel terminal, runs emergency procedure courses which include presentations from the police, fire service, ambulance service, occupational health and press office. This is to ensure that staff are aware of procedures and liaison with other services in the event of a critical incident. In addition, the emergency plans are tested through mock disasters every 12 to 18 months. The occupational health role in such mock disasters is limited, and the emphasis is on testing the first line response and NHS staff. However, it is important to recognise that the object of such an exercise is to make sure that people are as well prepared as possible and to minimise the impact of such an event. For these reasons, this type of training plays an important part in preparing individuals for major incidents.

Thankfully, major incidents are relatively few and far between. However, more common occurrences, such as the need to evacuate buildings/areas or keep staff informed of rapidly changing situations, can apply to many different settings.

**Evidence from case study organisations**

During less major incidents, where staff are still under continual pressure (e.g. in the event of a building evacuation or travel delays), the procedure is to bring in additional support and relieve staff of their duties far more frequently. In addition, there would be two duty officers (instead of one). This enables one manager to focus solely on operations, while the other is concerned wholly with keeping staff informed of what is going on, keeping them up to date and abreast of the situation, and reconfirming the plan of action.

**4.8 Information/education**

Many of our case study organisations were committed to informing staff about the potential reactions to a traumatic incident and the support in place. This education process takes many different forms.
Evidence from case study organisations

At a general level, leaflets and information booklets are widely available in many organisations, detailing:

- the nature of traumatic incidents
- the range of feelings often experienced by employees following an incident
- the usual recovery period, and
- the procedures to follow after such an experience, or further sources of help and information.

Many organisations also run awareness raising events to publicise the service and what it does, as well as to draw attention to the types of incidents that might cause problems.

Evidence from case study organisations

One of the case study organisations in the healthcare sector organised the promotion of its service in the following ways:

- leaflets widely distributed
- posters throughout the Trust in rest rooms etc.
- a half day awareness raising session for staff on responses to traumatic incidents immediately and in the longer term, including an introduction to the services provided by the Trust, and information on how they could be accessed
- the introduction of diffusing/defusing as a strategy that managers themselves might use, including small group exercises where managers are presented with scenarios and discuss how they might handle those situations, as well as procedures for initiating trauma management services for themselves and their staff.

Within the financial sector, several of the case study organisations used leaflets and booklets, as well as videos to explain possible symptoms and reactions, and to promote internal support services.

4.9 Conclusion

Many case study organisations are minimising risk and empowering staff in a number of ways. Activities fell into four broad categories:

- security measures
- training to prevent incidents
- training to manage incidents, and
- education in the possible consequences of incidents.

(cont’d)
On the whole, the case study organisations in this research recognised the importance of educating and preparing staff as much as possible, in terms of what to expect if an incident occurs at work. This was seen to have positive outcomes in terms of lessening the impact of an incident should it occur, and enhancing individual coping skills which could help to protect the employee from further psychological damage.

- Organisations should aim to recognise roles that are at risk from traumatic incidents at a corporate level as well as a local level.
- It is good practice to identify non-technical as well as technical key skills when filling vacant posts, for example, the ability to work under pressure and interpersonal skills.
- Good training for staff helps them to prepare for traumatic incidents and can reduce the likelihood of traumatic reaction.
- It is good practice to inform employees about the potential reactions of traumatic incidents so that they can recognise them if an incident occurs.

The clear message here was rehearsal of procedures and that it’s ‘good practice to practice’.
5. Managing the Post-incident Response

Key points

- Activities fall naturally into two broad categories: those associated with managing during or in the immediate aftermath of an incident, and those aimed at longer term management of reactions to the incident.
- Regardless of length or type of incident, defusing (or de-fusing) was a common way of staff dealing with the incident. Diffusing tended to be naturally occurring and happen on an informal basis.
- With four exceptions, debriefing was used in the days following an incident to help people deal with their feelings and to prevent the development of PTSD.
- In practice, the way debriefing sessions were conducted varied greatly from organisation to organisation, and differed from the original protocol set out for dealing with trauma in emergency service personnel. However, all debriefing activity was characterised by the following two points:
  1. That in some way debriefing would lessen the likelihood of subsequent traumatic symptoms; and
  2. That the debriefing process itself involved, at some stage, intense re-exposure to the incident.
- Despite its widespread use, it is not at all clear that debriefing benefits trauma victims. Some evaluations have suggested that it can cause more harm, by retraumatising individuals. Current thinking suggests that one of the reasons debriefing could be detrimental is that it involves people in intense re-exposure to the incident and that this could act as a secondary source of trauma.
- Despite this, the processes around debriefing (ie acknowledging individuals have experienced an extreme event, clearly identified procedures to follow, ongoing monitoring of staff well-being) are widely welcomed within organisations.
- Debriefing was almost invariably part of an overall approach to managing trauma in the workplace, and rarely used as a stand alone method.

This chapter reviews the way in which case study organisations respond to workplace incidents. Sadly, good quality evaluations of trauma management programmes are relatively sparse. Foa (1997) has suggested that research on the efficacy of psychosocial treatments for PTSD have only recently begun to approach acceptable standards. In part, this is due to the difficulty of satisfying the criteria for an empirically robust piece of research (eg reliable pre-incident measures, delayed treatment comparison groups and control groups etc.). Additionally, research method-
ologies are diverse, and as a result, research findings can be difficult to compare.

Having said that, more and more empirical studies of specific treatment approaches are now being undertaken and the findings published (Raphael et al., 1995; Foa, 1997). Additionally, a growing number of organisation-based opportunistic research studies have been reaching the public forum over the last few years (eg Tehrani, 1996, 1998; Letts and Tait, 1994). This work provides a valuable insight into the workings of trauma management programmes in a real world setting.

The activities of the case study fell naturally into two sections:

- policies and procedures in the immediate aftermath of the incident, and
- longer term management of reaction to the incident.

Both these areas are discussed in turn.

5.1 Immediately after the incident

Many factors appear to influence the ways in which organisations plan to manage incidents. The overriding factor that differentiates the management strategies of our case study organisations is that of time or duration of the incident. The types of incident range from an armed raid (usually 45 seconds to a minute) to potentially up to twelve hours on a shift.

Clearly, such variations in the type of incident being managed place very differing demands on staff, and consequently approaches vary enormously. For this reason, analysis of the incident management data is split broadly into long or short incident duration.

What is of interest, however, are the striking similarities for all organisations in the way that the immediate aftermath of an incident is managed. This holds true regardless of the nature of the incident itself.

5.2 Incidents of short duration

Many of the short term incidents with identified management procedures were either armed raids or incidents of physical or verbal assault. The case study organisations dealing with such types of incidents were those in the financial, public, retail and health sectors.

On the whole, managerial protocols were operational in nature and the psychological support aspects featured more in dealing with the aftermath of an incident. This is largely due to both the
speed of the incident (ie little time to react) and the powerlessness of the individual to make decisions.

5.2.1 The financial sector

In the event of a raid, advice (apart from instruction not to tackle raiders) focuses almost wholly on what happens next. The main action points can be summarised in the following way:

- ensure all staff are safe
- secure the premises and retain all customers (as potential witnesses)
- alert the police
- alert own security services
- alert area or regional office, and personnel or HR.

Many interviewees in financial sector organisations commented on the ‘confusion’ after a raid, in the sense that:

‘There are lots of people milling around the branch; in the aftermath of a raid there are a lot of people there: police; security; occupational health; and regional office people.’

For all financial sector organisations, the people arriving at the branch had specific functions. For example, their roles included:

- testing of security systems
- acting as liaison between staff and police to minimise the burden on staff
- arranging for relations and family to be called in case they had heard about the incident via the media
- dealing with media enquiries
- advising on technical aspects, eg ensuring that names only (not addresses) appear on witness statements and removing (or overseeing police removal) of CCTV footage from cameras (to ensure staff are not called to a prosecution in this respect)
- checking the well-being of staff, ensuring that no-one was returning to an empty home etc.
- providing advice on what would happen next.

5.2.2 Same day diffusing

In all financial organisations researched, quite heavy emphasis was placed on same day diffusing (or debriefing).
Evidence from case study organisations

Basically, the emphasis is on conducting a meeting for staff before they go home to encourage everyone to discuss what has happened and how they have reacted to it. It is felt to be important to avoid shutting out the incident. The aims of diffusing vary slightly from organisation to organisation, but can be broadly summed up in the following ways:

- to help staff to come to terms with what has happened
- to offer reassurance and support
- to get people to focus on facts and give information
- to explain the roles of all the other bank or building society personnel there, and
- to explain the subsequent help that is available should it be required.

Table 5.1 Diffusing

<table>
<thead>
<tr>
<th>Stage</th>
<th>Phase</th>
<th>Domain</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>Cognitive</td>
<td>To introduce intervention team members, explain process, set expectations.</td>
</tr>
<tr>
<td>2</td>
<td>Exploration</td>
<td>Cognitive to affective to cognitive</td>
<td>To discuss the traumatic experience. This is achieved by having each participant relate to the facts of the event. Inquiry is also made into any cognitive or affective reactions to the event. Finally, participants are encouraged to discuss any symptoms or ‘unusual’ reactions they had in response to the traumatic event.</td>
</tr>
<tr>
<td>3</td>
<td>Information</td>
<td>Cognitive</td>
<td>To ensure that participants have returned to the cognitive domain in their processing of the event. This is achieved by teaching trauma concepts and stress management techniques while attempting to ‘normalise’ symptoms.</td>
</tr>
</tbody>
</table>

The Post Office

Stage 1 Crisis Management (first 24 hours)

In the first hours after an incident, the main focus of support for the individual is managing the crisis. The line manager’s role is to manage this process and to ensure that the immediate physical and psychological needs of everyone involved are met. The manager also provides information on debriefing, the normal symptoms of trauma and other support which is available. Although there are operational and business needs which must be met following a traumatic event, the Post Office always aims to put the needs of its traumatised employees first.

5.2.3 The health sector

In the trusts visited, management protocols existed for both short and long duration incidents. Plans for managing short duration incidents tended to be less formal and to operate at a local level (as opposed to eg major accident planning which was designed and implemented at a corporate level).

Evidence from case study organisations

On a more frequent level, particularly difficult incidents that occurred on the shift — for example, incidence of verbal abuse/physical assault — were managed primarily through diffusing. This was particularly true in a ward situation towards the end of a shift. Normally this is instigated by the senior nurse and aims to allow staff to discuss what has happened and to ensure their well-being. This is felt to be a very natural process which happens fairly informally and was in place before they were familiar with ‘diffusing’.

In the A&E situation, the same is true. Diffusing happens in a fairly unstructured and informal way, and tends to focus on a discussion of what happened that day/night and what caused people concern. In this setting the diffusing also has a proactive capacity in that the manager is keen to understand the ‘nitty gritty’ of problems. This enables them to monitor, for example, violent or aggressive patients, or if the problems are internal (such as an aggressive doctor) they can pick up on the situation and attempt to resolve it.

5.2.4 The public sector

Within the non-healthcare public sector organisations researched, responsibility for critical incident management protocols or emergency procedures was often devolved to a local level, with procedures being reviewed after any incidents to identify learning points. However, there were exceptions to this.

Evidence from case study organisations

In one organisation, guidelines for dealing with ‘very serious incidents’ were issued centrally and aimed to provide a checklist for action which covered all needs. This included suggestions on a very practical level (eg closing the curtains to avoid press intrusion) aimed at minimising the further consequences of the incident. The guidance is comprehensive and covers such areas as:

- ensuring medical help has been summoned if appropriate
- ensure police have been called if it is an assault incident
- close office and draw curtains (to avoid press intrusion)
- organising a team to move into the office and deal with communications and operational issues
- contacting next of kin and arranging transport (eg to hospital)

(cont’d)
• contacting the employee assistance services for immediate support over the telephone
• sorting out arrangements for staff to get home and ensuring that no staff suffering from shock return alone to an empty house
• arranging to provide individuals with any information they may need after the incident with regard to eg personal injury claims or damage to personal property
• ensure that work is covered and the physical environment is restored to normal as soon as is possible, and
• encourage people to return to work as soon as they feel able as those who return early recover more quickly from the emotional shock.

5.2.5 Utility sector

One case study organisation in the utility sector identified problems as a result of the 24 hour delay before their trauma management intervention took place.

Evidence from case study organisations

These problems were due to the necessity for the organisation to investigate accidents etc. with a view to establishing facts and apportioning blame. It was apparent to Occupational Health that while the investigations were conducted, employees should be in a supportive environment. Also, at that time, Occupational Health became aware that not only employees who had been injured or who had witnessed the event, but also the supervisors who had to conduct these accident investigation interviews, were exhibiting signs of having been traumatised by their experiences. The response to these observations was the development of a Serious Incident Support Programme which trained supervisors, ie anyone with responsibility for staff between one to 100 employees, in how to handle their staff when they were at their most vulnerable. This was identified as the critical few hours after the incident and before the accident investigation interview.

5.3 Long duration incidents

In longer duration incidents, management protocols tend to emphasise different methods for ensuring the support of staff during the incident. The type of incidents considered here involve workers in a major travel terminal where there may be travel delays, bomb threats, other safety alerts requiring evacuation of passengers; fire and rescue service personnel; and A&E personnel.
Evidence from case study organisations

For the travel terminal and the A&E department, ensuring adequate support for staff during an incident included increasing staffing levels for predictably busy periods and calling in additional support if necessary.

Staff would be relieved of duty far more frequently, and additional senior staff could be called in to monitor the situation and keep all staff informed of developments.

In the example of the travel terminal, informal diffusing occurred during or at the end of a shift. During a shift it was felt important to allow staff to get back to a ‘natural hub’, i.e. a control room or rest area which acted as a natural setting for diffusing with colleagues. If it was felt necessary at the end of a shift, the duty manager would instigate a diffusing session.

In the A&E example the manager works very closely with staff so was able to monitor how they were coping with the situation. A debriefing session would be held at the end of the shift if necessary.

5.3.1 Fire and rescue service

At an incident, procedural regulations are clearly stated (e.g. about length of time spent in breathing apparatus, or at the scene before a break and there is usually provision for rest). Psychological welfare is not formally specified, but informally the incident commander or senior officer at the scene would monitor the welfare of their staff.

There is a very strong culture within the fire and rescue services which is based on colleague support and humour. For the most part firefighters who work together on a watch hold the view that ‘the watch can sort itself out’ (and that is considered the way it should be).

Diffusion was the first line of reaction among the fire and rescue services researched. If a situation is felt to be out of the ordinary, or any firefighters appear to be particularly bothered by an incident, a diffusion session will normally be instigated informally by the senior officer when the crew are back at the station, ‘round the table with a cup of tea’.

5.4 Conclusions

- Whatever the nature of the incident, however long the duration, diffusion is almost uniformly the first line of response. In almost all cases there was no formal diffusion training. Several interviewees said that they had always done this — before they had ever heard of diffusion.
- From the perspective of the case study organisations, we can conclude that the importance of diffusing should not be underestimated.

(cont’d)
• In many situations, it happens informally, without the benefit of any training, but appears to play a critical role in the process of allowing staff to discuss and review, or make sense of what has happened.

• Aside from diffusing, there were a number of procedural responses for managing incidents or their immediate aftermath. Usually, the priority of the organisation was to provide back-up and support so that individuals could be relieved from duties and assisted as much as possible with fulfilling any security obligations (e.g., police statements).

• Often, post-incident management involved specific technical or practical advice which aimed to mitigate against any further escalation of the situation. For example, not putting addresses on police statements (to which any defendants in a case have access), ensuring only police or security advisers remove CCTV or video footage so that employees do not become involved in the ‘chain of evidence’ and can even extend to, for example, drawing curtains to exclude media intrusion.

• It is evident from these examples that there are many general and specific ways in which organisations can prepare to deal with traumatic incidents and the way that they can manage in the immediate aftermath of such incidents.

• Appropriate protocols and training can be established through thorough risk assessment.

5.5 Managing in the days that follow an incident

By far the most commonly used form of post-incident intervention found among our case study organisations was that of psychological debriefing. Debriefing has been applied, in its many forms and guises, in a wide range of UK organisations in response to traumatic incidents. The next sections of the report look at debriefing in detail and then turn to other post-incident interventions.

Responses to the Delphi exercise (see Appendix 1)

Trauma managers report encountering many difficulties when managing people after a traumatic incident. There are particular issues surrounding debriefing, such as:

• reluctance to participate in the procedure
• peer pressure to avoid the debrief
• lack of support from senior staff, and
• deliberate undermining by individuals not present at the incident.

Other contradictions for trauma managers included:

• Having to carry on with the job so that post-incident management is often not given the time it requires. After several attacks it is difficult to know what to say or do as it has been done and said before.

• Having to discipline people after an incident.

(cont’d)
Trauma managers reported trying to resolve the difficulties they have experienced in the following ways:

- informing senior staff of the benefits of debriefing in terms of health, safety and absenteeism
- developing a set of rules to eliminate disruptions, and
- including those not directly involved in incidents to participate in operational debriefs or discussions so that points of learning are addressed in open forum.

Trauma survivors identified a number of positive actions by their employers that they felt had aided their recovery and return to work. These included:

- providing and paying for counselling and further referral to a Clinical Psychologist as necessary
- offering the services of Employee Support
- assigning staff to alternative duties, and
- organising retraining for a new post.

Where some trauma survivors felt that employers had failed to assist their recovery was in:

- not giving personal help to return to a suitable position at work, and
- failing to give support and advice after the employee effectively lost their job.

### 5.6 Origins of debriefing

The principles of crisis intervention have been used in military settings since the First World War, with a view to returning officers identified as acute psychiatric casualties to active combat duty as soon as possible. Modern day debriefing was first proposed by Mitchell in 1983.

Two authors, working independently, devised the intervention following exposure to traumatic stress referred to as ‘debriefing’ — Mitchell (1983) and Dyregrov (1989). Mitchell named his technique ‘Critical Incident Stress Debriefing’ (CISD), while Dyregrov referred to his simply as ‘Psychological Debriefing’ (PD). The need for such an intervention arose initially out of Mitchell’s field observations of firefighting and emergency medical service workers and other observations of psychological distress in emergency workers, leading on from exposure to traumatic incidents which involved physical or psychological threat, either direct or indirect (Mitchell, 1983; Dyregrov, 1989; Parkes, 1991).

#### 5.6.1 Aims of debriefing

Mitchell’s original goals for CISD were simply to:
1. mitigate the harmful effects of traumatic stress on emergency personnel, and

2. accelerate normal recovery processes in normal people, who were experiencing normal reactions to abnormal events.

He believed that CISD would be an important factor in the prevention of PTSD and post-traumatic stress in high-risk occupational groups (Mitchell, 1983, 1988a, 1988b, 1991). Busuttil and Busuttil (1997) present the aims of both Mitchell and Dyregrov’s techniques as:

‘... to diminish the impact of catastrophic events by promoting support and encouraging processing of traumatic experiences in a group setting; to facilitate the piecing together of traumatic information while personal experiences are normalised and participants are helped to look into the future and to attempt to accelerate recovery before harmful stress reactions have the chance to damage the performance, careers, health and families of victims.’

In summary, the aims of debriefing were to diminish symptoms in high risk groups, which has important implications when considering evaluations of debriefing techniques.

5.6.2 Timing of debriefing

Formal CISD is recommended for use between 24 and 72 hours after the incident. This time delay was considered necessary as Mitchell (1983) proposed that emergency workers could suppress psychological reactions for a brief period after an incident as a result of ‘training’, and would otherwise be too aroused to deal with an in-depth discussion of events.

5.6.3 Who should attend?

Importantly, both Mitchell (1983) and Dyregrov (1989) propose that formal debriefing should be mandatory for all participants. The purpose of the follow-up CISD, at several weeks after the incident, is to resolve issues arising as a result of the incident. Mitchell (1983) suggests that it is closely associated with therapy and remarks that it is possibly the hardest to conduct.

Mitchell and Dyregrov (1993) finally came together and proposed a seven-phase debriefing protocol for formal debriefing which will be examined in more detail. The seven phases adapted from Mitchell and Everly (1993) are shown in Table 5:2.

The recommended time allowance for the formal debriefing is two to three hours. Dyregrov (1989) advises against variations from the model, as set out, due to an increased risk of penetrating too deeply beyond an individual’s healthy and necessary defence mechanisms.
Table 5.2 Debriefing

<table>
<thead>
<tr>
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<th>Phase</th>
<th>Domain</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>Cognitive</td>
<td>To introduce intervention team members, explain process, set expectations.</td>
</tr>
<tr>
<td>2</td>
<td>Fact</td>
<td>Cognitive</td>
<td>To have each participant describe a traumatic event from his or her personal perspective.</td>
</tr>
<tr>
<td>3</td>
<td>Thought</td>
<td>Cognitive to affective</td>
<td>To have each participant describe his or her cognitive reactions to the event and to begin the transition to emotional reactions.</td>
</tr>
<tr>
<td>4</td>
<td>Reaction</td>
<td>Affective</td>
<td>To have each participant identify the most traumatic aspect of the event to facilitate affective catharsis.</td>
</tr>
<tr>
<td>5</td>
<td>Symptom</td>
<td>Affective to cognitive</td>
<td>To allow the identification of personal symptoms of distress and transition back to the cognitive level.</td>
</tr>
<tr>
<td>6</td>
<td>Teaching</td>
<td>Cognitive</td>
<td>To educate about normal relations and adaptive coping mechanisms (ie stress management). Provide a cognitive anchor.</td>
</tr>
<tr>
<td>7</td>
<td>Re-entry</td>
<td>Cognitive</td>
<td>To clarify ambiguities and prepare for termination.</td>
</tr>
</tbody>
</table>

5.7 Debriefing in practice

In fact, many different approaches to debriefing were advocated by our case study organisations. For example, in some cases, debriefing was operated in isolation, whereas in others it was part of a package of interventions or practices concerned with post-incident reaction.

In the way debriefing was deployed there were also huge variations across organisations. For example:

- debriefing was used both in groups and with individuals
- the models used were often adapted to the needs of the individual organisations
- there was much variation in the timing of a debrief after an incident had occurred
- in some organisations, attending debriefing is mandatory, in others it is on a voluntary basis
- in some organisations debriefing is open only to those directly involved in the incident, in others it is open to (or mandatory for) all staff in that office, for example.

The objectives of debriefing also vary enormously among case study organisations and ranged from showing organisational concern to minimising risk of litigation.

In fact, there were only two similarities that were consistent in the way that all organisations undertook debriefing:
1. That in some way debriefing would lessen the likelihood of subsequent traumatic symptoms; and
2. That the debriefing process itself involved, at some stage, intense re-exposure to the incident.

Debriefing in practice varies greatly from the protocols originally set out by Mitchell and Dyregrov. This means that debriefing cannot be assumed to have the same impact or outcomes.

5.8 What is known about the efficacy of debriefing?

5.8.1 Can debriefing reduce subsequent PTSD symptoms?
The importance of randomised controlled trials

As described in earlier chapters, following a traumatic experience many people are likely to suffer from some traumatic symptoms such as flashbacks or hyperarousal. This is considered a normal reaction in the short term, and in most people such symptoms will diminish over the next few weeks. PTSD or Adjustment Disorder is only considered as a diagnosis if symptoms persist for over four weeks.

This means that the only definite way to tell if debriefing reduces subsequent traumatic symptoms is through randomised controlled trials. Therefore, after an incident, individuals are assigned to either a debriefing group or a control (non-intervention group) on a random basis. This idea of random allocation is important as it means that in theory the only difference between the two groups is whether or not they were debriefed.

Measures of symptoms need to be taken for both groups at an early stage (Time 1) to check there are no differences between the groups in the level of symptoms they are experiencing. Measures of symptoms need to be taken again at later dates (Time 2, normally after four weeks, when symptoms will have diminished anyway — and in the longer term at, for example, six and 12 months).

If the group which received debriefing is experiencing significantly lower levels of traumatic symptoms, then debriefing has been proven to be effective in reducing traumatic symptoms.

5.8.2 Has debriefing been shown to reduce subsequent PTSD symptoms?

The main problem with attempts at evaluation above, is that only a very small minority have been randomised controlled trials. The majority of studies carried out so far have failed to demonstrate adequately the beneficial effects of debriefing, or indeed any prevention of post-traumatic symptoms, which is a stated aim of the process.
There have been only six randomised, controlled studies of debriefing conducted to date. These studies provide mixed findings on how effective debriefing is in reducing subsequent traumatic symptoms. On the whole, they show no differences between those who received debriefing and those who did not. There is also some evidence, albeit flawed, that debriefing might have a detrimental effect.

**Recommended research papers**

Wessley, Rose and Bisson (1998), 'A systematic Review of "Debriefing"', *The Cochrane Database of Systematic Reviews*


Many (non-randomised controlled) studies have suggested that debriefing works because symptoms for many in the group have all but disappeared three to four weeks later. However, the majority of people who experience trauma symptoms after an incident will naturally recover within three to four weeks, regardless of whether or not they are debriefed.

Others have recognised the difficulties surrounding the evaluation of debriefing and have advised as follows:

1. Debriefing should be carried out as part of an overall crisis intervention programme, and never without a follow-up.

2. It should be carried out with careful thought in regard to the group involved, and modified if necessary.

3. It should be carried out only by experienced clinicians, focusing on cognitive aspects and education.

4. It should not be carried out too early, that is within 48 hours.

5. Sessions should not attempt to achieve too much, and should not be too short.

6. It should be seen partly as an assessment procedure to identify those who are at risk, and as a way of establishing engagement with such individuals.

*Source: Coping with Catastrophe*, Hodgkinson and Stewart, 1998
5.9 Evaluation and monitoring of debriefing in case study organisations

Two of the case study organisations had methodologically robust evaluations in place, capable of distinguishing whether or not debriefing was effective in reducing traumatic symptoms.

Most organisations had some form of evaluation, or other objective measures, in place (e.g., sick leave following an incident), or some form of monitoring of staff outcomes in the longer term. This section of the report will look first at evaluation work being done by organisations, and then at monitoring.

5.9.1 Evaluations of debriefing

Both examples come from the health sector where there is ready access to clinical or research expertise in designing and managing this type of research.

Evidence from case study organisations

In the first example, people approaching the staff welfare service following an incident are randomly assigned to an information only or a debriefing group. Measures of symptoms are taken and individuals are sent information, or go through a debriefing usually within two weeks of the incident. Measures are taken of symptoms at three and 11 months following the incident. This evaluation has been running a relatively short time and low numbers mean it cannot provide conclusive results yet. However, it provides an excellent example of how such evaluations can take place in an applied setting.

The second example of evaluation has been in operation for several years and has currently led to a review and reformatting of the service.

Evidence from case study organisations

The research took place with volunteers, and individuals were not randomly allocated to treatment or control groups, but looked at the impact of debriefing on individuals and asked for their assessments of the service provided.

Three questionnaire sets were prepared for administration to the same individuals, identified only by a self-selected code at three specific stages in the debriefing process.

The first questionnaire set was designed to be completed by debriefing participants prior to their debriefing. Participants also received the booklet How to Cope with Stressful Events and an information sheet explaining exactly what a debriefing is. Different trauma symptoms and the frequency with which they were experienced were measured.
The second questionnaire set was to be completed by all those who attended a debriefing within one week of the meeting to assess the impact of the psychological debriefing and participants' reactions to what went on during the group session. This questionnaire comprised of the same measures that were administered prior to the debriefing. In addition it contained a questionnaire dealing specifically with what was experienced during the psychological debriefing. This was presented in ten sections which related to the process of debriefing and an overall assessment about the level of knowledge achieved on long-term adjustment difficulties, and access to further sources of help.

The third questionnaire set was to be circulated one month after the debriefing meeting. This comprised of the same measures as used at Times 1 and 2, but here with the instruction to report reactions experienced during the last seven days.

Between 1991 and 1995, 40 debriefings were conducted. The findings revealed that emergency personnel gave generally high ratings of the helpfulness and relevance of debriefings following critical incidents, with the most important process being the sharing of experiences. However, these ratings of satisfaction were not related to a reduction in traumatic symptoms:

- Participants who reported higher levels of traumatic symptoms immediately after the incident showed the least symptomatic change.
- Those who exhibited low degrees of distress initially were more likely to report finding the process most useful.
- The biggest reductions in traumatic symptoms were observed among those participants who had access to social support in the post-incident phase.

The conclusion, therefore, was that 'a distinctive beneficial impact of psychological debriefing could not be demonstrated'.

The results of this study, together with the findings from other research literature (such as that outlined above), led the team providing the service to run a consultation exercise about the way forward, and the way in which the service could be developed.

As a result, the emphasis has now shifted away from debriefing and towards providing a more flexible and evidence-based service, and enables resources to be focused on those who are more at risk.

5.9.2 Monitoring of debriefing

Many of the case study organisations had in place monitoring systems that allowed them to check on people’s progress following debriefing. The most commonly used form of monitoring is the Impact of Events Scale which measures the frequency with which individuals experience traumatic symptoms.
In this way, organisations are able to tell if any individuals are still experiencing high levels of symptoms, and in some instances this can be used to make a referral for further help and support.

In several organisations, monitoring is performed on a much less formal level, with personnel, HR, and occupational health people keeping an eye on anyone who has been involved in an incident, and checking for any signs of ongoing problems.

5.10 Why debriefing might not work

The lack of positive feedback on the effects of debriefing in reducing traumatic symptoms has led researchers to seek explanations for why debriefing doesn't appear to fulfil this objective.

Firstly, it is important to recognise the differences between the randomised controlled trials that have taken place and the original purposes for which debriefing was designed. There are two differences that might affect outcomes.

All randomised controlled trials report on:

- one-to-one debriefing sessions — not group debriefs for which the process was originally intended, and
- (with the exception of one) primary victims of trauma (eg admissions to a burns unit, admissions to A&E department and road traffic accident victims). Debriefing was originally designed for use with emergency service personnel who are secondary victims of trauma, ie they are carrying out their normal duties, but might be affected by a particularly extreme situation.

This is not to suggest that debriefing therefore 'works' in groups or in emergency service personnel. Rather, it points to the urgent need for more methodologically sound research in these areas.

5.10.1 Expert thinking on debriefing

Some expert interviewees also suggest a difference in reactions between one-off events when the individual has no time to act, and other events which allow time to take decisions and make choices, particularly where behaviour under pressure, when reviewed by the individual, falls below their own internal standards.

There is also some evidence, albeit limited at present, that certain individuals are more at risk from secondary traumatisation during debriefing. The risk factors that have been proposed are:

- the duration and intensity of exposure to the trauma
• the extent to which an individual dissociates (ie distances themselves from the experience), and

• other factors, such as: how much the individual identifies with the victim (emergency services personnel especially), whether they were able to do anything, or whether they felt helpless, and their own psychological state at the time of the incident.

Dissociation is believed to predict PTSD more than any other factor. Current thinking is that talking during dissociation may well be re-traumatising some individuals.

There are a number of possible reasons why debriefing might be associated with an adverse effect in some. First, because of the general finding that any effective treatment, even psychological treatments, must always have with it some risk of adverse effects in some — the question at issue is always the balance of risk and effects.

There are also some reasons why debriefing might have a specific adverse effect in some. Several advocates of debriefing have considered the possibility of ‘secondary trauma’. Debriefing involves intense imaginal exposure to a traumatic incident within a short time of the event. It is possible that in some individuals this serves as a further trauma, exacerbating their symptoms without assisting in emotional processing. Exposure therapy, as practised for the treatment of established PTSD, may lead to an initial mild exacerbation of symptomatology as distressing images are recollected. The principles of exposure therapy suggest that such distress lessens as habituation occurs over time. However, in a single intervention, such habituation may not occur unless the recipient engages in further self directed exposure.

Another explanation is that debriefing may ‘medicalise’ normal distress. It may also raise the expectancy of developing psychological symptoms in those who would otherwise not have done so. No matter how great the trauma, it is a constant finding of the traumatic stress literature that not everyone develops psychological distress, and it is usually only a minority who progress to formal long term psychiatric disorder. Debriefing, by increasing awareness of psychological distress, may paradoxically induce that distress in those who would otherwise not have developed it.

Debriefing also assumes that there is a uniform, and to a certain extent predictable, pattern of reactions to trauma. At the heart of the treatment is the concept that discussing the trauma is therapeutic, and that attempting to deny it is not. This is based on a time honoured tradition of psychological thought. However, it does not follow that this is true in every case. Recalling the event may be a ‘secondary trauma’ — attempting to forget/distance oneself may be an adaptive response.

A further problem is that debriefing, by definition, focuses on the single trauma. However, even if all the victims of a disaster were exposed to a uniform event, they are certainly not uniform in any other respect. Focusing attention of a single traumatic event may divert attention away from other important psychosocial non-traumatic factors that differ between victims.

Source: Wessley et al. (1998)
5.11 Why do debriefing?

Other researchers have recognised that the evidence for the efficacy of debriefing is very poor, and acknowledge that debriefing might harm some people (Raphael et al., 1995). They consider other reasons why debriefing has been so widely applied and remains a popular approach to the treatment of post-incident reactions.

Raphael et al. (1995), propose that debriefing meets many needs: the needs of survivors to articulate what has happened, understand it and thereby gain control; the symbolic needs of workers and management to aid those who suffer and display concern; and the needs of those not directed to master vicariously the traumatic encounter, overcome their sense of helplessness and survivor guilt, and to make restitution.

CISD has been adopted as received wisdom and enjoyed a phenomenal spread of application and use in major disasters etc. since the early 1980s. Raphael et al. (1995), interestingly describes it as ‘social movement’ or ‘ideology’. It seems to have been adopted as an article of faith by those groups who need to make a response and have to rely on received wisdom.

Others suggest that while there is no evidence that debriefing ‘works’ to reduce symptoms, what it does seem to do is make people feel better. eg scenario: a person reports thinking they’re going mad after an event because they have the symptoms. If they are told the symptoms are a normal reaction and they aren’t going mad they are relieved. The symptoms don’t go but the associated anxiety reduces, therefore they feel better. Also the process is a useful short circuit for getting at those feeling isolated — the people who feel that ‘no-one can help me’.

It may be that looking for symptom reduction over time is inappropriate simply as a result of the physiological changes associated with traumatic memory. Debriefing is controlling, not eradicating, symptoms.

5.12 Other benefits of debriefing

Other researchers have already noted that although debriefing might not help in the reduction of traumatic symptoms, the process itself does not appear to have other benefits for different groups within the organisation.
For those who have experienced trauma it has been proposed that the process of debriefing:

- helps people to articulate and understand what is happening (this is reinforced by the evidence from one of our case studies presented above), and
- to make people feel reassured that any symptoms they might be suffering from are a normal reaction to an abnormal situation.

For co-workers and managers, it has been suggested that the process of debriefing allows them to:

- display concern for their colleagues
- deal with feelings of helplessness and survivor guilt, and
- deal with their own (vicarious) feelings of trauma.

Evidence from our case study organisations reinforced many of these points. Debriefing was said to be broadly welcomed by employees, to be a positive experience and have an important role in their feelings that the organisation has acknowledged what has happened to them.

Another important aspect of the process highlighted by many organisations and by expert interviewees was the learning aspect.

Understanding what has happened in an incident, allowing trauma survivors to explain, in their own words, in a supportive and blame-free setting has been an unforeseen benefit in providing information and practice that can be used outside the debriefing meeting itself.

Clearly then, it would appear to be the case that although debriefing does not itself reduce trauma symptoms, the processes that it has introduced into organisations are broadly welcomed and valued for reasons other than symptom reduction.

5.13 Management or treatment?

Trauma does not always lead to pathology; most reactions to trauma are not PTSD. Several of the clinical experts contacted in the course of this research suggested that only a small proportion of people who survive a trauma go on to actually develop PTSD. It was suggested that given the small proportion who do go on to experience negative outcomes, it would seem a waste of professional resources to intervene clinically with someone who will recover as a matter of course. The difficulty is in identifying the individuals who will require and benefit from clinical intervention.
This theme of not ‘treating’ people who are following normal recovery patterns is echoed elsewhere, most notably in the research literature.

Debriefing appears to offer a fusion between a clinical treatment of debatable benefit and a highly valued management process. The next section attempts to disentangle the two.

Organisations need to consider precisely what their aims are in using different forms of interventions to deal with traumatic reactions following the incident. Are they attempting to treat trauma victims, or to manage the incident?

<table>
<thead>
<tr>
<th>Table 5:3 How the debriefing process differs from the management process</th>
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<tbody>
<tr>
<td>Prior to debrief</td>
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<tr>
<td>Debriefing session</td>
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<tr>
<td>Stage 1: Introduction</td>
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<td>Stage 2: Fact</td>
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<td>Stage 3: Thought</td>
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<td>Stage 4: Reaction</td>
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<td>Stage 5: Symptoms</td>
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<tr>
<td>Stage 6: Teaching</td>
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<tr>
<td>Stage 7: Re-entry</td>
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<tr>
<td>After debriefing</td>
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</table>

The Institute for Employment Studies
5.13.1 What is management, what is treatment?

Arguably, many aspects of debriefing could be considered as aspects of managing an incident. The only areas in which the debriefing process is clearly different from a management process are in Stages 3, 4 and 5, where debriefing takes participants through a period of intense re-exposure to the event itself (see Table 5:3).

It is this period of intense re-exposure (Stages 3, 4 and 5) to the incident, that could arguably be described as the ‘clinical’ or treatment element of the debriefing, that research findings and experts have suggested is problematic and could result in secondary traumatisation.

It is also this element of the debriefing that distinguishes it from a formal diffusing session.

5.14 Other approaches to symptom reduction

In almost every case study organisation there was provision for further support and counselling if appropriate. The type of counselling available varied from in-house provision to use of external specialists, such as the Centre for Traumatic Stress based in London. Some arrangements were fairly ad hoc and had evolved from pre-existing arrangements for general counselling rather than trauma-specific counselling.

On the whole, these services were largely unevaluated, the main problem being that the numbers being referred on were so low that such evaluation would be meaningless.

There is limited evidence from research that the most effective forms of counselling in treating traumatic symptoms are those based on cognitive or behaviour therapy (Foa et al., 1997; Wessley et al., 1998).

5.15 Conclusions: the way forward

- Diffusion was found to be in practice in some form or other in most of the organisations visited. In many instances, this was a naturally occurring phenomenon and was described by staff as something that occurred ‘before we’d ever heard of diffusing’.
- In shorter duration incidents, management protocols tended to advise on actions immediately after the event and have an operational focus.
- Longer duration incidents tended to emphasise different methods for ensuring support of staff in performing their duties.
- By far the most commonly used form of post incident intervention among the case study organisations is that of debriefing, however there were wide variations in the ways that debriefing was adapted to different organisational needs.

(cont'd)
• In fact, the question of whether debriefing meets its stated objectives of reducing traumatic symptoms can be difficult to evaluate and only six random controlled studies have been completed to date.

• Findings from the studies have been mixed, with the most recent studies (where debriefing involves intense re-exposure to the traumatic incident) suggesting that at best debriefing has no benefit and in some circumstances could possibly be harmful.

• On the whole, it would appear that the jury is still out on the subject of debriefing and more research will be needed to establish whether or not it works in different settings and whether or not it is suitable for all people.

• Two of the case study organisations visited had excellent evaluation systems in place, demonstrating how debriefing can be evaluated in an applied setting.

• Many case study organisations had monitoring in place which allowed them to check on people's progress following the debriefing session.

• Although debriefing has not been proven to reduce traumatic symptoms, there were found to be many other benefits associated with its use.

• Most important were the management systems for dealing with incidents and allowing staff the opportunity to talk to each other about their experiences and make sense of what had happened.

• This raises the issue of whether organisations are trying to manage or treat trauma symptoms. It highlights the need for organisations to set very clear and realistic aims down for any intervention that they propose to use, and for them to constantly monitor or evaluate the outcomes against the stated objectives.
6. Conclusions and Recommendations

6.1 The context of this report

Most people who experience a traumatic incident do not go on to suffer from PTSD. Many, however, are likely to experience trauma symptoms.

Some people may experience traumatic symptoms in response to sequential, but less individually devastating incidents.

The extent to which trauma is a risk for different occupational groups is not consistently documented. However, the evidence is clear that both unusual or everyday work occurrences can lead to the experience of post-traumatic symptoms.

Employers’ responsibilities under the ‘duty of care’ legislation applies to their employees’ psychological as well as their physical well-being. Cases of ‘nervous shock’, essentially psychiatric illness as a result of trauma in the workplace, are still relatively uncommon and such rulings issue from common law so can be considered as being in a process of development and refinement.

Recommendations

To understand the scale and nature of difficulties attention should be focused on the experience of post-traumatic symptoms rather than diagnoses of PTSD.

Employers should be encouraged to undertake thorough risk assessments to identify workplace hazards which could lead to the experience of post-traumatic symptoms.

6.2 Risk assessment and psychosocial hazards in the workplace

Unlike assessment of physical hazards where the harm caused is likely to be direct and objectively measurable, assessment for psychosocial hazards is complicated by a number of issues including, for example, individual differences in response to the same degree of exposure.

The risk of hazards will vary from workplace to workplace and their potential for causing harm will vary from person to person. This makes it impossible to produce a list of potential hazards
that should be assessed for, although there is a degree of consensus over types of work that need to be considered.

Most importantly, organisations need to consider the methods they have available to them in conducting risk assessment. Employees’ reports of workplace problems do not reflect a true risk unless there is also associated harm.

Much information for assessing psychosocial hazards will already exist in an organisation. Desk research can play a vital part in understanding types of incidents and identifying how well existing policies and practices relate to these situations. Other methods can include self-report questionnaires and interviews.

**Recommendations**

Assessment of psychosocial hazards needs to build up a picture based on several different sources of information including the hazards themselves, the evidence that they cause harm and the management procedures already in place.

Organisations should be encouraged to investigate how well existing reporting procedures reflect the true situations within their organisations.

It is essential to establish the causal links between hazards and harm if risk assessment is to be effective.

### 6.3 Pre-incident activities

Many different measures and approaches to avert hazards were evident in the case study organisations we visited. These provide an excellent illustration of how risk assessment can inform a number of HR and organisational policies and practices.

Many pre-incident activities occurred on a formal footing. However, there was also evidence of locally organised pre-incident activity, where a hazard had not been recognised at a corporate level.

In relation to HR procedures, our case study organisations demonstrated examples of pre-incident activity in selection and recruitment, as well as in a variety of training and educational exercises on the job. These could be identified as:

- security measures and procedures to minimise the opportunity for incidents to occur
- training or guidance to help staff prevent incidents from occurring
- training or guidance on what to do when an incident occurs, and
information and education on the likely consequences of an incident, and the support and help available if required.

The clear message from this research is that it is good practice to practice. Once procedures are in place, they should be maintained through regular rehearsal.

Recommendations
Organisations should be encouraged to review pre-incident activities on a regular basis and should identify any informal practices of merit which could be promoted at a corporate level.

Regular rehearsal of emergency or critical incident procedures should be encouraged to ensure that in the event staff will know the protocol to follow.

6.4 Managing the post-incident response

Management of the post-incident response covered a wide range of both policies and procedures, with an operational focus as well as the longer term management of individual reactions to an incident.

As would be expected, policies and procedures with an operational focus were dictated by the nature of the incident and tend therefore to be situationally specific.

One striking finding from the research was the similarity with which personnel in many organisations managed the immediate aftermath of an incident with some form of diffusing, whether it is a formal policy or not.

Regardless of setting or type of incident, diffusing was found to occur in most organisations. Many reported that this was very much a natural phenomenon. Others pointed out that it had always happened, prior to anyone there hearing about ‘diffusing’.

Some of the organisations visited had formalised this ‘diffusion’ process and had trained staff in place to run such sessions.

Aside from diffusing, there were a number of procedural responses for managing incidents or their immediate aftermath. Usually, the priority of the organisation was to provide back-up and support so that individuals could be relieved from duties and assisted as much as possible with fulfilling any security obligations (eg police statements).

Often, post-incident management involved specific technical or practical advice which aimed to mitigate against any further escalation of the situation. For example, not putting addresses on police statements (to which any defendants in a case have access), ensuring only police or security advisers remove CCTV
or video footage so that employees do not become involved in the 'chain of evidence'. Such advice can even extend to, for example, drawing curtains to exclude media intrusion.

By far the most commonly used form of post-incident intervention found among our case study organisations was that of psychological debriefing, also known as Critical Incident Stress Debriefing. This is a procedure that was primarily developed for use with emergency services personnel.

The original goals for debriefing were simply to:

1. mitigate the harmful effects of traumatic stress on emergency personnel, and

2. accelerate normal recovery processes in normal people who were experiencing normal reactions to abnormal events.

There were found to be many variations in the way debriefing was deployed in different organisations. This means that debriefing cannot be assumed to have the same outcomes across different organisations or settings.

In fact, there were only two similarities that were consistent in the way that all organisations undertook debriefing:

1. That in some way debriefing would lessen the likelihood of subsequent traumatic symptoms; and

2. That the debriefing process itself involved at some stage intense re-exposure to the incident.

There have been only six randomised, controlled studies of debriefing conducted to date. These studies provide mixed findings on how effective debriefing is in reducing subsequent traumatic symptoms. On the whole, they show no differences in symptom level between those who received debriefing and those who did not.

Two of the case study organisations had methodologically robust evaluations in place, capable of distinguishing whether or not debriefing was effective in reducing traumatic symptoms. They provide excellent examples of how evaluation of debriefing can be conducted in an applied setting.

Reasons as to why debriefing might not be meeting its objective of reducing traumatic symptoms are the subject of much debate at the present time. The wisdom of employing debriefing methods to reduce traumatic symptoms without close evaluation has to be questioned.

Other researchers have recognised that the evidence for the efficacy of debriefing is very poor, and acknowledge that debriefing might harm some people. They consider other reasons
why debriefing has been so widely applied and remains a popular approach to the treatment of post-incident reactions.

It has been proposed that debriefing meets many needs: the needs of survivors to articulate what has happened, understand it and thereby gain control; the symbolic needs of workers and management to aid those who suffer and display concern; and the needs of those not directly involved, to master vicariously the traumatic encounter, overcome their sense of helplessness and survivor guilt, and to make restitution.

Evidence from our case study organisations reinforced many of these points. Debriefing was said to be broadly welcomed by employees, to be a positive experience and have an important role in their feelings that the organisation has acknowledged what has happened to them.

Debriefing appears to offer a fusion between a clinical treatment of debatable benefit and a highly valued management process. The key issue appears to be one of treatment or management. Generally ‘treating’ people who are reacting normally is not considered good practice. However, the sensitive management of traumatic incident is clearly of high importance.

Debriefing involves a period of intense re-exposure to the incident. It is this element of debriefing that could arguably be described as the ‘clinical’ or treatment element of the process and current debate suggests that it is this element of debriefing that is problematic and could result in secondary traumatisation.

Aside from debriefing, almost every case study organisation had provision for further support and counselling if appropriate.

**Recommendations**

Organisations not already doing so formally should explore the potential benefits of diffusing, and identify whether such an approach is appropriate to their organisational setting.

It is essential that organisations have very clear and measurable aims for any post-incident intervention, against which performance of the intervention can be judged.

The jury is still very much out on debriefing. Organisations who wish to use this procedure should also set in place proper evaluation procedures to ensure that debriefing is meeting the objectives set for it.

If no appropriate evaluation is possible then it would be advisable to consider dropping the intense re-exposure to the incident from the process.

Debriefing should not be mandatory, but participants should be encouraged to go, as the processes of understanding what happened and sharing experiences are rated as extremely helpful by debriefing participants.

(cont’d)
6.5 Overall

The case study organisations visited had in place many exemplary practices and procedures for managing trauma in the workplace.

A key aspect of this good practice is that it was rare to find one initiative working alone. In virtually all organisations visited, there were a package of measures in place, including risk assessment, selection and recruitment measures, training and education, rehearsal of critical incident procedures, clearly defined practices and policies for managing incidents wherever possible, clear guidance on dealing with the immediate aftermath of an incident, as well as longer term support for employees. All of these approaches, adapted to differing organisational needs, serve to reduce the likelihood of incidents occurring and to minimise the harm when they do.
Appendix 1: Methodology for Delphi

The Delphi method involves the selection of a panel of at least ten individuals with particular expertise in a well defined area and asking them, individually, to put forward their views which can then be presented back to the panel, collectively, for evaluation. Several iterations may be necessary for consensus to be achieved in the areas required. To be successful, this method requires careful selection of the panel of experts and their continued participation in the process.

It was originally proposed that the Delphi element of this project would contribute to establishing criteria for the management of trauma in the workplace and allow examples of best practice to be identified.

In discussion with HSE it was decided to enlist the co-operation of two panels of experts, trauma survivors and trauma managers, each with very clearly defined selection criteria. Mindful of the ethical considerations of approaching individuals who had suffered a traumatic reaction to incidents in the workplace, and having sought and been granted ethical approval for our methods, attempts were made to contact and enlist those individuals we defined as experts.

The criteria for a ‘trauma survivor’ were: an individual who has experienced an incident in the workplace which has given rise to a traumatic reaction; who has been absent from work for a period of time; who has experienced some sort of therapeutic intervention via their employers, and who has returned to and has been functioning in the workplace for a period of not less than one year. These criteria were selected to ensure that the individuals did have the relevant experiences and that any possible re-traumatisation by being asked about the incident would be minimised. Clinical support was explicitly made available, should it be required by any trauma survivor. We identified potential trauma survivors initially from our case study organisations by asking key individuals that we contacted if they could identify any of their staff who met our very stringent criteria. If these key individuals could identify such individuals they were asked to speak with them initially, on behalf of the project team, and enlist their support. Following a verbal agreement, a more formal written agreement was obtained from these survivors. This was achieved by obtaining the names and addresses of survivors from the key individuals.
we had contacted and writing directly to them, giving a brief outline of the project and details of what would be required of them should they agree to participate in the Delphi. A second copy of the introductory letter was enclosed and survivors who wished to participate were asked to sign this letter and return it in the pre-paid business envelope supplied. In practice, it became necessary to speak with contacts across all the sectors we were investigating, clinicians who we knew had treated trauma survivors who met our criteria, and other personal contacts, to identify subjects for this part of the project.

Trauma survivors who agreed to participate subsequently received a copy of the first round questionnaire, entitled ‘Surviving Traumatic Incidents in the Workplace’. Three trauma survivors returned the questionnaire and an additional survivor completed the questionnaire in response to a follow-up request letter, giving a total of four from the original pool of survivors who had actually agreed to participate. Unfortunately, we have no way of knowing why those survivors who originally agreed to participate in the Delphi failed to do so on receipt of the questionnaire.

Regarding ‘trauma managers’ it was originally envisaged that these individuals could be identified from within our case study organisations and defined in terms of having facilitated the recovery and the return to work of at least one trauma survivor who met our criteria. It quickly became apparent that our scope was far too narrow, and thus it was broadened to include the occupational health and welfare professionals who actually made the decisions regarding an individual’s suitability for returning to the workplace. Of the trauma managers who agreed in writing to participate in the Delphi, and despite follow-up reminder letters, only two trauma managers responded with completed questionnaires.

It is clear that had all those individuals who agreed to participate actually done so, the Delphi could have proceeded. It may be useful to speculate why those individuals who agreed to participate failed to do so. The demands of the workplace often mean there is insufficient time for ‘extraneous’ paperwork; the content may not have been relevant to the person’s experience, though hardly in this case; avoidance of reminders of traumatic incidents may be a common method that both survivors and managers use to cope with their experience, and there are many other unknown reasons.

Nevertheless, the data we have been able to obtain provides the only valid account of what actually does happen to individual survivors and those facilitating their recovery in the workplace, and as such lend vital support, qualification and in some instances negation to the notions of best practice that we have obtained from our experts and case organisations in the field.
Conclusion

The main conclusion that can be drawn from our experience of the Delphi is that there are far fewer trauma survivors and successful (in our terms) trauma managers currently in the workplace than we originally anticipated. We now have some knowledge of the frequency of potentially traumatic incidents in the workplace and prevalence data, and yet have had immense difficulties in finding survivors in the workplace. It could be that those who experience traumatic reactions from incidents they have experienced in the workplace are leaving organisations, perhaps on ill-health related pensions, rather than returning. One might then surmise that organisations are currently failing to manage traumatic stress reactions in the workplace, and individuals thus affected are having to leave organisations to effect a recovery. It would therefore be useful to investigate where the victims of trauma ‘end up’, ie with GPs, clinicians etc. Maybe post-incident traumatic stress is not currently being managed in the workplace, merely being moved outside.

NB: None of the trauma survivors were working in the same job as they were prior the incident. While survivors may ultimately return to the workplace, they do not wish to be in posts which may trigger reminders of the incident.
Appendix 2: Methodology for the Case Studies

Case study organisations were identified in three ways:

- through research literature on trauma management
- through trade and industry articles on trauma management, and
- through discussions with researcher and practitioner experts in PTSD and workplace trauma.

As far as was possible, organisations were selected to represent a broad array of industrial sectors and occupational backgrounds. However, it was essential for research purposes to establish that participating organisations had clear trauma management practice in place. As a result, the sample is inevitably biased towards emergency services and the financial sector where trauma management principles are strongly established.

The final sample consisted of 18 case studies, some organisations being multiple businesses covering occupations as diverse as mineral extraction and high street retail. The sample consisted of three fire and rescue services; one joint emergency service; one ambulance service; two banks; three other financial sector organisations; one public sector government agency; one accident and emergency department; one mental health trust; one utility company; one multinational production company; one entertainment business; and two travel based organisations (one in passenger transportation and the other operating a major passenger travel terminal).

When considered in terms of the Standard Industrial Classification, case studies or businesses within case study organisations cover the categories highlighted in the table overleaf.
<table>
<thead>
<tr>
<th>Letter</th>
<th>Industry Description</th>
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<tbody>
<tr>
<td>A</td>
<td>Agriculture, Hunting and Forestry</td>
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<tr>
<td>B</td>
<td>Fishing</td>
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<tr>
<td>C</td>
<td>Mining and Quarrying</td>
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<td>D</td>
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<td>F</td>
<td>Construction</td>
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<td>G</td>
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<td>Hotels and Restaurants</td>
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<td>Q</td>
<td>Extra-territorial Organisations and Bodies</td>
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Appendix 3: Case Study Questions
Managing Post-incident Trauma in the Workplace: Case Studies

Company:

Interviewees:

Date:

Interviewer:

Introduction

One of the aims we want to achieve through the research is to learn more about the ways in which organisations prepare for and deal with incidents that can lead to the onset of Post Traumatic Stress Disorder (PTSD) and other associated disorders among employees, as well as the support mechanisms in place to assist them once the condition has been diagnosed.

Reassure them that the information they give will be treated with the strictest confidence and that they will not be identifiable in any report of the work.

Wherever possible, collect documentary evidence of eg monitoring; evaluation; management reports; policy statements; information for staff etc.
Strategic level (ie the person responsible for H&S, welfare, or HR at board/senior management level within the organisation)

Background information on the organisation

1. Nature of business; what are the main products/services of the organisation?

2. What is the total no. of whole time equivalents in the organisation?

3. Main occupational breakdown and broad description of type of work.

(probe on)

Are there any jobs with special physical or psychological requirements?

Are there any jobs with known physical, chemical, biological or psychological hazards?

Trauma management policy

1. Get their full description of their policy and trauma management service/activities.

2. Get a full history of how the service came about (why did it develop in that way?)

   - Who is responsible for service delivery? (NB: may be different people for different parts)

3. What does the service seek to achieve?

   - Aims/objectives/statement of intent?
   - Internal (staff, systems etc.) and external (media, legal etc.) focus?

4. What evaluation of the service takes place? (What is regularly seen/reviewed by senior management?)

   - How does this relate to the objectives?

5. What, if any, cost benefit analysis is undertaken? (If not why not?, any plans to in the future?)

6. How does the Trauma management policy relate to other management strategies? (probe for: security policies; COSHH; job design; selection and recruitment; training; managing absence etc.)
• For each one, how do the policies inform each other, what impact has the trauma management policy had on other areas of work?

**Risk assessment (if not covered above)**

1. What is done in this area?

2. What, if any, crisis management work do they do? (training etc.?)

3. Who is it targeted at?

4. How evaluated? Against what objectives?

**Overall**

1. How does their approach to trauma management fit into general health and safety responsibilities? (Probe for knowledge/understanding of responsibilities etc.)

2. Do they have any future plans for developments in the area?
   • If yes, what plans and why?

3. Who is responsible for security assessment/crisis management planning? (and can we interview them please?)
The service delivery level (ie the person/people responsible for conducting trauma management activities)

Here the aim is to gain an understanding — primarily through the description of ‘an event’ — of how the service works with regard to managing incidents and employee support.

Event management

1. Can you think back to a (recent) event involving staff which required the involvement of (which serves as a good example of the work done by?) the trauma management team/service (whatever their term is). Thinking of this event:

- Can you describe the circumstances leading up to the event.
- Who was involved in the event (role and responsibilities)?
- What happened?
- What was the result for staff/public (any other groups involved)?
- How did the trauma management services get involved (standard, or due to specific aspects of the event or the results)?
- What was their involvement (in detail, over what time span, links to what other parts of the organisation)?
- Involvement of other services (eg fire, police, ambulance) — how did it work, what complications etc.?
- Involvement with media? — how handled?/who had contact? Strategy already in place? Outcomes/fair coverage?
- Legal involvement? Compensation claims? How handled? Who had contact?
- Long term — absence rates? Medium/long term follow-up? Return to work within what time scale? How planned return to work? Job design issues etc.? Medical retirements?
- Lessons for the service — what aspects of the service worked well? What didn’t work so well? What changed as a result?
- Lessons for the organisation? What happened differently as a result?
Background to the service

1. Get a full (historical) description of the systems or responses that are in place to deal with work based incident trauma
   - Get details of any changes/developments to the service and how they came about.

The way the service operates

1. What are the specific types of responses offered or strategies in place and their objectives? Probe for how the system(s) works eg referrals; who’s involved at what stage; how it relates to NHS provision (or other medical insurance) Who the system(s) is open to (line managers, colleagues, spouses, families etc.

2. Is there any identification of ‘at risk’ jobs or groups of employees and if so, who are the groups and (for each group) how are they identified/defined? (Especially the process — based on careful monitoring or someone’s intuitive feel that X might be a difficult job?) Is there a specific service/strategy etc. in place for them?

3. Details of any monitoring and evaluation against objectives (what tools/measures are used, timing, long term follow up etc.).
   - What does the monitoring/evaluation show?
   - What is the usual level of information fed back to management?
   - Strengths and weaknesses of the service — what changes would they make?

4. Future developments for the service?

5. Links to other parts of the organisation (eg security/training/staff briefings/ HR and selection/recruitment/job design etc.)
   - For each one, how do they link in to that part of the organisation? (Communications, influence on strategy/decision making etc.)

6. How do they (if at all) undertake the assessment of risk and how does this contribute to any preventative strategy?
Managers who have experience of their staff using the service

Thinking back to an incident when you or your staff have used the trauma management service:

- Describe the incident — what were the circumstances leading up to the incident?
- Any prior training/expectation/preparation about the incident?
- Who was involved?
- What happened — procedures afterwards etc.
- Feelings after the incident — how did trauma management service get involved? (standard procedure vs specific request?)
- Media/legal contact?
- What was the involvement?
- How did staff react?
- How did you feel about it as a manager?
- Long term consequences for staff?/sickness absence rates etc.
- Specific guidance to you as a manager on how to handle staff return to work — what support was offered?

General information

1. Prior to using the service, what did the manager(s) know of it (how was it publicised etc.)?

2. What are the referral procedures? Probe for who makes the decision to refer an individual/team/group to the service (especially, how confident are managers about making referrals — is it seen as their responsibility? And what briefing do they get about how the service should be used?)

3. What is their understanding of the information and advice that is available? Probe for types of situations covered/understanding of symptoms etc.

Process

1. Once an individual/team/group has been referred, what information is communicated to the manager?

2. What ongoing communication and support is there?
3. How is the individual managed during the process (eg type of work, workload etc.) OR What planning is undertaken for individuals return to the workplace? Who is involved, is a formal (action?) plan agreed etc.

**Evaluation**

1. How do they view the service?

2. What impact has it had for them as staff managers?
### Appendix 4: Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>acute</td>
<td>The sudden and severe onset of symptoms.</td>
</tr>
<tr>
<td>aetiology</td>
<td>The study of causation, in particular, what causes certain mental disorders and other illnesses.</td>
</tr>
<tr>
<td>affective/affectivity</td>
<td>Related to feelings or emotions, and the propensity to react with feeling or emotion.</td>
</tr>
<tr>
<td>anxiety</td>
<td>A stressful reaction characterised by fear, apprehension or dread. In some mental disorders, the reaction may be chronic and may damage both psychological and physical health.</td>
</tr>
<tr>
<td>arousal/hyper-arousal</td>
<td>Being constantly alert to a threat, regardless of the true risk. This shows itself in things like insomnia, being easily startled, irritability, etc.</td>
</tr>
<tr>
<td>ASD</td>
<td>Acute Stress Disorder</td>
</tr>
<tr>
<td>avoidance</td>
<td>Attempts to avoid recalling events, emotions, reminders etc., in this context, those associated with a traumatic event. Numbing is another symptom of avoidance.</td>
</tr>
<tr>
<td>BDI</td>
<td>Beck's Depression Inventory. A general mental health, self-report measure.</td>
</tr>
<tr>
<td>BSI</td>
<td>Brief Symptom Inventory. A general mental health, self-report measure.</td>
</tr>
<tr>
<td>CAPS</td>
<td>Clinician Administered PTSD Scale. A structured interview measure of PTSD.</td>
</tr>
<tr>
<td>caseness</td>
<td>When individuals are tested for things like PTSD, a cut-off point is decided for scores. Those scoring above this threshold are considered to have the mental problem being tested for. These people are called ‘cases’ and hence, the test is being administered to establish ‘caseness’.</td>
</tr>
<tr>
<td>chronic</td>
<td>Experienced over a long time period, usually used to indicate periods of one year or more.</td>
</tr>
<tr>
<td>CISD</td>
<td>Critical Incident Stress Debriefing</td>
</tr>
<tr>
<td>cognitive/cognition</td>
<td>The mental process which involves people in thinking, conceptualising, imagining, conceiving, remembering, judging, perceiving, etc.</td>
</tr>
<tr>
<td>debrief(ing)</td>
<td>Debriefing may take place at the scene of the traumatic event, or some days afterwards. It is the process by which traumatic reactions are investigated, confronted and integrated into the memory. Debriefing may be one-to-one or in groups.</td>
</tr>
<tr>
<td>defusing/diffusing</td>
<td>A discussion of immediate reactions and feelings which takes place within a few hours of a traumatic event.</td>
</tr>
<tr>
<td>DIS</td>
<td>Diagnostic Interview Schedule. A structured interview measure of PTSD.</td>
</tr>
<tr>
<td>dissociation</td>
<td>Individuals may split off distinct parts of their mental life, eg work and home, and function separately in each of them. Their behaviour in different spheres may even be contradictory.</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.</td>
</tr>
<tr>
<td>GHQ</td>
<td>General Health Questionnaire. A general mental health, self-report measure.</td>
</tr>
<tr>
<td>ICD</td>
<td>International Classification of Mental and Behavioural Disorders, produced by the World Health Organisation.</td>
</tr>
</tbody>
</table>
ideation The process by which ideas are formed.

IES Impact of Events Scale. A self report measure of avoidance and intrusion symptoms.

imaginal flooding As images are used to encode and represent memories, unwanted memories may be ‘over-written’ if the mind is flooded with alternative images while the event is being recalled.


morbid Abnormal, diseased or disordered.

neuropsychologic The interface between the nervous system and psychological processes.

numbing A reduction in general responsiveness, an avoidance symptom. This may be displayed in feelings of detachment from others, a sense of foreshortened future and a reduction in interest in previously important activities.

PD Psychological Debriefing.

pharmacotherapy Treatment with drugs.

PK-MMPI Keane PTSD Sub-scale of the Minnesota Multiphasic Personality Inventory. A self report measure of many PTSD symptoms.

psychophysiology/ic Using non-intrusive methods of measuring physiological processes to get information about psychological processes, eg measuring the electrical conductivity of the skin, and thereby perspiration in order to deduce level of distress.

psychosocial Where a behaviour or mental process has either a social origin or impact.

PTSD Post-traumatic Stress Disorder.

PTSD-I Post-traumatic Stress Disorder Interview. A structured interview measure of PTSD.

re-experiencing Traumatic events particularly, have the capacity to intrude into current thoughts. Individuals may re-experience trauma, eg have flashbacks of their experiences and all of the emotions which went with it. Re-experiencing may also manifest itself in nightmares, or in children through repetitive play.

SCID Structured Clinical Interview for DSM III-R. A structured interview measure of PTSD.

sensitivity The ability of a test for PTSD to pick up very low levels of symptoms in individuals and populations.

sequela/sequelae A morbid condition following from and because of an illness, mental or physical.

specificity How well a measure of PTSD can differentiate it from other mental health problems.

Stimulus-response A stimulus is any object or event which causes an effect on an individual. Stimulus-response theory suggests that human behaviour can be understood in terms of set responses to stimuli, ie A causes B to happen.

stressor The things people report as causing them stress.

threshold The cut-off point for a score or scale which aims to measure some type of mental illness. Those who exceed the score are ‘above threshold’ and can be classed as having the disorder in question.

Source: IES/Drever & Wallerstein, 1984/Stratton & Hayes, 1993
Appendix 5: Trauma Management Practices

The following practices have been collected from case study organisations in the research to provide general information on how employers minimise the risk and manage the consequences of trauma in the workplace. They represent practical approaches to trauma management which would readily transfer to many different workplaces.

Risk assessment

For the main part, organisations understanding of possible sources of trauma to staff were based on historical evidence, task analysis and record keeping, or on other sources of data where applicable.

Historical data

Many case study organisations kept records of previous incidents which enabled them to understand the nature of risks to which their staff could be subjected. This data could be quite varied in nature, from accident reports and absence records to police and firearms statistics. Often, collection of this data was mandatory (eg reporting accidents etc.) or for security purposes as opposed to being collected primarily for risk assessment of traumatic incidents. However, it provided a useful starting point for understanding the types of incidents that staff could experience through work. Examples of the organisations where historical data was used included financial, retail, health and the public sector as well as private sector organisations with a high degree of contact with the public.

The purpose of collecting such data varied depending on the main type of risk (eg financial and retail settings, where the main perceived risk was from raids or hold-ups as opposed to dealing with difficult customers/patients). However, the factors which could influence the degree of risk were broadly similar. Historical data helped organisations to develop a detailed understanding of the degree of risk associated with such characteristics as:

- geographical location (national);
• physical location (immediate environment) or site of incident (if transporting goods/money);
• physical layout of building;
• different security devices (eg rising vs. fixed screens);
• seasonal variations in risk; and
• timing of raids (daily or weekly variations).

This information could then be used in a range of ways, from advising on the site of new premises, or their interior layout to improving security practices and staff training within sites.

Record keeping

Several of the case study organisations visited had developed record keeping systems based around specific types of risk that had been identified. The benefits of this more detailed record keeping were twofold in that:

• They allowed a far clearer picture of the demands or risks of a particular task. An example of this would be the reporting of each incidence of verbal and (threatened) physical abuse whereas legislation requires the recording of only those incidents leading to three or more days absence from work. It is possible that jobs involve aspects of risk that remain hidden from standard recording procedures. Yet understanding why some situations escalate in to ‘incidents’ and others do not could be essential in successfully managing the risk.

• They could often be used proactively to inform decision making on a day to day basis. Examples of this included:
  
  • a mental health care setting, where information including medical condition, medication and the patient’s reaction to previous visits could influence the decision to visit a patient at home, conduct the visit with a colleague or call the patient in to a clinic; or

  • working away from the office/lone worker roles where knowledge of eg a site to be visited or the nature of the task, determined whether the task was conducted alone or in pairs;

  • daily or weekly variations in workload required additional staff or staff with specific skills to be on hand.

In all examples, record keeping was tailored to the specific risk factors identified in the job and seen as an important way of minimising risks to employees.
Risk management/pre-incident activities

A wide range of procedures and practices existed within organisations for managing the risks associated with different aspects of jobs. These stemmed directly from risk assessment and recognition of the particular hazards associated with any job.

As a result, approaches to managing risk are wide ranging and can include anything from physical location or layout of a premises to specific training courses for staff.

Preventative strategies

Reported strategies included;

- changing the location of premises;
- changing the physical layout;
- changing opening hours;
- introducing (and advertising) closed circuit television;
- introducing other physical security measures; and
- changing work roles or re-designing jobs.

Procedures and practices in place

For many of the organisations studied, establishing clear procedures and practices was seen as essential in reducing the risk of traumatic incidents occurring. These included;

- establishing and promoting protocols to ensure safe methods of working;
- providing detailed checklists for guidance in an emergency situation; and
- ensuring clear channels of communication and support.

Training and education

In several organisations task specific training and education activities had been developed to support implementation of the safe working protocols already established. Examples of this included;

- practise emergency calls in an ambulance service;
- conducting raid drills in a bank;
- rehearsing major incident procedures (including involvement of police and emergency services)

As a general rule, whatever the nature of the likely traumatic incident, some form of rehearsal of specific procedures was seen as very good practice. Organisations who adopted this approach
reported positively on both the actions of staff if/when an
incident arose and their general confidence about what to do
and what was expected of them.

Other forms of training were generic and could apply to a
variety of settings, these included courses in customer handling
skills or in recognising how and when situations were escalating
and techniques for avoiding confrontation.

Many organisations also trained managers in how to handle staff
who had experienced a traumatic incident. This could take the
form of advice on how staff might react and guidance on what to
do, or in some cases managers were formally trained in diffusing
techniques and part of their remit was to hold a diffusing session
following a traumatic incident.

A final aspect of pre-incident education is that of providing
employees with information about traumatic events and
possible reactions as well as promoting the trauma management
services that are in place.

Trauma management

The majority of case study organisations identified several
strands to trauma management. The primary concern reported
was immediate care of staff. This was followed by any security
requirements and other demands. Review of the incident was an
important aspect of trauma management for many organisations
and feeding the findings back in to risk assessment and
preparation. Over a longer period there was also the monitoring
of staff well-being.

Immediate care of staff

Most organisations provided guidance on the immediate care of
staff following an incident. Inevitably, any response will be
determined by the nature of the event. However, depending on
the situation organisational guidelines include:

- ensure staff are safe;
- ensure premises are secure;
- contact the police/emergency services
- contact internal security
- alert personnel, senior managers, trauma support services;
- contact next of kin/family/friends;
- arrange cover to relieve staff of duties;
- arrange transport home;
- ensure no one is returning to an empty home;
• provide information on procedures/sources of support;
• arrange a diffusing session; and
• arrange a debriefing session.

Immediate care of staff could also extend to such activities as eg having in place a system for dealing with media enquiries and protecting staff from media intrusion, as well as eg where a police investigation results, identifying responsibility for dealing with the police and relieving staff of the burden as far as is possible.

Diffusing was found to happen (often quite informally) in all case study organisations. This very naturalistic process tended to occur immediately after an event, or at the end of the day/shift. Reports from interviewees suggest that it plays an important role in helping staff to come to terms with what has happened, to enable people to offer reassurance and support and, where it occurs more formally, to be one of the processes by which staff can be informed of what other help and support is available.

Formal debriefing was also a common response in many case study organisations. Given the current debate about the efficacy of debriefing, it is important for organisations to be clear about why they use the process and what benefits it has for staff. Good practice in debriefing involves having clearly stated objectives for the debriefing process (ie is the purpose to reduce traumatic symptoms, reduce the likelihood of absence from work or is it to provide employees with information and an opportunity to understand and try and make sense of what has happened). Organisations should then monitor not only satisfaction with debriefing services, but subsequent experience of traumatic symptoms. Ideally, where possible this should be done against a control group. However, given that this will be impractical in some organisations, results can at least be monitored against what is known of the normal reactions to traumatic incidents. Monitoring is also important in identifying those who might need longer term support (see below).

Reviewing the process

For the most part, organisations concentrate on identifying the facts of a situation or the series of events that lead to a situation and looking at how well existing control measures, procedures and practices performed. The emphasis is very much on identifying whether changes in procedure are required or whether there are learning points from a situation. This process is broadly similar in all organisations. The main difference is whether the review is conducted locally, in relation to local practices or is conducted at an organisational level and any learning shared across the organisation.
Ongoing support

Virtually all case study organisations had some form of longer term support available to employees who continued to suffer from traumatic symptoms after the normal recovery period. Generally, uptake of these services was reported to be very low. The services themselves were usually part of existing counselling services available within the organisation in question.

Currently, the evidence from research is that counselling approaches based on cognitive and behavioural therapies are most successful in reducing trauma symptoms.

Other forms of long term support focus on helping individuals back into work, retraining or re-deploying following a period of absence. The need for this type of support was very low amongst case study organisations. As a result, such procedures were not necessarily formalised in relation to trauma, but the organisation worked with employees on an individual basis.

Overview of practice

Inevitably precise procedures and activities varied according to organisational needs and the nature of the work undertaken by their employees. What is clear from the research, however, is that best practice is found amongst those organisations with clear and well developed practices in risk assessment and risk management, as well as in trauma management.
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