

The Mass Violence and Early Intervention Expert Consensus Guidelines

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The Mass Violence and Early Intervention Workshop, held October 30th to November 1st, 2001, was the first of its kind to assemble a group of 60 experts from around the world with the goal of developing a consensus document of this kind. The conference was sponsored by a number of agencies, including the Department of Defense, the Department of Justice, the National Center for PTSD, the National Institute of Mental Health, and the Red Cross.

The following consensus statements are intended to support all facets of health care. They are organized around the following six questions:

- I. What current good practice would be recommended in mass violence situations, as a set of early interventions?
- II. What should the key operating principles be?
 - what should be done and why
 - what should not be done and why
 - what is the range of options for action in different circumstances
- III. What are the issues of timing of early intervention?
- IV. What is appropriate screening?
- V. What is appropriate follow-up, for whom, over what period of time?
- VI. What expertise, skills, and training are necessary for early interventions, at what level of sophistication?

Mass Violence and Early Intervention

For the purpose of this document, an early intervention is defined as any form of psychological intervention delivered within the first four weeks following major incidents or disasters. Once established services may remain in place for the long term. Some of the components of early intervention will be provided by mental health (MH) personnel; others of these components have mental health implications but will be provided by others.

Consensus was reached on the following issues. There were some issues on which consensus was not reached and contrasting scientific interpretations are footnoted. Some

of those issues have been reframed as research or ethical questions that can benefit from further scientific inquiry and discourse.

1. KEY OPERATING PRINCIPLES OF EARLY INTERVENTION

Key components of early interventions include preparation, planning, education, training, and service provision for those affected by major incidents and disasters.

A sensible working principle in the immediate post-incident phase is to expect normal recovery. The assumption of clinically significant disorder in the early post-incident phase is inappropriate.

Mental health personnel must be integrated into the major incident or disaster management teams and should help coordinate service provision so that mental health is an integrated element of comprehensive disaster management plans. Mental health expertise can help guide the implementation of interventions to maximize positive mental health outcome.

Early mental health assessment and intervention should focus on hierarchy of need: starting with survival, safety, security, food, shelter, health (both physical and mental), triage (mental health triage for emergencies), orientation (helping survivors become oriented to immediate local services), communication with family, friends and community, and other forms of psychological first aid.

Key aspects of early intervention shall include: psychological first aid, needs assessment, monitoring the recovery environment, outreach/information dissemination, technical assistance/consultation/training, fostering resilience, coping, and recovery (i.e., facilitating natural support networks), triage, and treatment. (Please see appendix A for description of each).

Good practice in early intervention also takes into account the special needs of those who have experienced enduring mental health problems, those who are disabled, and other high risk groups disadvantaged so as to be less able to cope with unfolding situations.

Interventions should be tailored to address individual, community and cultural needs and characteristics.

Early interventions should typically seek to address diverse outcomes, with the aim of promoting normal recovery, resiliency, and personal growth. Collective outcomes should also be addressed, such as social order and community / unit cohesion.

Adverse outcomes to be targeted by early interventions include: acute stress disorder (ASD), post-traumatic stress disorder (PTSD), depression, complicated bereavement reactions, substance use disorders, poor physical health, fear, anxiety, physiological arousal, somatization, anger control, functional disability, and arrest or regression of childhood developmental progression.

It is essential that the specific components of early intervention be identified, operationalized, and used for service delivery, research, education and consultation activities. See appendix A for a description of early intervention components.

The term "debriefing" should only be used to describe operational debriefing, not psychological debriefing, critical incident stress debriefing (CISD), etc.

(Operational debriefing is a routine, individual or group review of the details of an event from a factual perspective, for the purpose of: (a) learning what actually happened for the historical record or planning process, (b) to improve future results in similar missions, and; (c) to increase the readiness of those being debriefed for further action. Operational debriefings are conducted by leaders or specialized debriefers according to the organization's standing operating procedure).

Use of the term "debriefing" for a variety of mental health interventions (described as psychological debriefing, critical incident stress debriefing (CISD), etc.) is misleading. This term should no longer be used to define early interventions following major incidents and disasters.

Participation of survivors of mass violence and trauma in early intervention sessions, whether administered as group or individual help and support, should be voluntary.

2. BEST PRACTICES BASED ON CURRENT RESEARCH EVIDENCE

Few randomized, controlled trials (RCTs) have been done to establish the distinct outcomes that can be achieved for survivor populations through early intervention following major incidents and disasters. Thoughtfully designed and carefully executed RCTs have a critical role in establishing parameters for best practices.

(RCTs are a type of experimental research involving comparison of a group that receives the study intervention and a group that receives other care or no intervention. Participants are randomly assigned to one of these groups and may be matched for key demographic characteristics. This study design permits researchers to assess cause-and-effect relationships and can be used to determine intervention effectiveness).

(The Agency of Health Care Policy and Research's (AHCPR) has defined a system of classification for levels of evidence in scientific trials. In the statements below, Level 1 evidence, which is considered "the gold standard," refers to randomized, well-controlled clinical trials).

There is limited Level 1 evidence to definitively confirm or refute the effectiveness of any early psychological intervention following major incidents and disasters. The current evidence, often drawing on other types of traumatic events, permits the following conclusions:

- There is some Level 1 evidence for the effectiveness of early, brief and focused psychotherapeutic intervention (provided on an individual or group basis) for bereaved widows, parents, and children.
- There is some evidence from Level 1 studies that selected cognitive behavioral approaches may help reduce incidence, duration and severity of acute stress disorder (ASD), post traumatic stress disorder (PTSD) and depression in trauma survivors (e.g. following accidents, rape, and crime).
- There is some Level 1 evidence suggesting that early interventions in the form of a single 1-to-1 recital of events and expression of emotions evoked by a traumatic event (as advocated in some forms of psychological debriefing) does not consistently reduce risks of later developing PTSD or related adjustment difficulties. Some survivors (e.g., those with high arousal) may be put at heightened risk for adverse outcomes.
- There is no evidence showing that EMDR (eye movement desensitization and reprocessing), as an early mental health intervention following major incidents and disasters, is a treatment of choice over other approaches.

3. KEY CONSIDERATIONS FOR TIMING OF EARLY INTERVENTION

Early interventions should be delivered as needed in a manner acceptable to service users and in keeping with best available expertise. Little research evidence (particularly Level 1), has been published on which to base judgement about the optimal timing for early interventions.

Data should be collected through systematic research and evaluation so that the timing of early intervention can be informed by reports published and scrutinized in the public domain.

In view of the current lack of specific research data on optimal timing of early interventions, consensus workshop participants have developed a set of recommendations (see appendix C) that describes (amongst other elements) various types of early interventions and the timing believed by the authors of this statement to be most appropriate for their delivery. As new evidence is published, this guide can be revised, extended and developed to include goals of each intervention, their uses with specific populations and types of disaster, as well as the most appropriate systems to be put in place for their delivery.

4. APPROPRIATE SCREENING FOR SURVIVORS

Screening and needs assessments for individuals, groups and populations are important for the provision of informed early intervention following major incidents and disasters.

Specific screening methodologies used for individuals or groups considered at high risk for chronic PTSD and other serious mental health outcomes following major incidents and disasters should be evaluated to ensure that their use is both safe and effective.

Screening programs for trauma related problems should conform to Institute of Medicine (IOM) or similar standards for safety and efficacy (<http://www.quic.gov/report/toc.htm>).

5. APPROPRIATE FOLLOWUP, FOR WHOM AND OVER WHAT PERIOD

Follow-up should be offered to individuals and groups at high risk of developing adjustment difficulties following exposure to major incidents and disasters, including those (a) with acute stress disorder or other clinically significant symptoms stemming from the trauma; (b) who are bereaved; (c) who have a pre-existing psychiatric disorder; (d) who have required medical or surgical attention and; (e) whose exposure to the major incident and disaster is known to have been particularly intense and of long duration.

Follow-up should be offered to those who request it.

Many trauma survivors experience some symptoms in the immediate aftermath of a traumatic event. These are not necessarily cause for long-term follow-up since, in most instances, symptoms will eventually remit. Those exposed to traumatic events and who manifest no symptoms after a period of time (approximately two months) do not require routine follow-up, but follow-up should be provided if requested.

Precise statements as to exactly when follow-up should occur in each individual case is not possible due to the many significant variables that inform clinical recommendations for early intervention.

6. EXPERTISE, SKILLS AND TRAINING REQUIRED FOR PROVIDERS OF EARLY INTERVENTION SERVICES

Individuals who provide early mental health interventions or consultations need to remain within the scope of their expertise and education, making appropriate referrals when additional expertise is needed.

Individuals who provide early interventions or consultations should be sanctioned by, and must operate within the incident command structure responsible for coordinating major incident and disaster response. This should include quality assurance reviews which ensure that helpers have proper documentation to certify their training credentials, plus the required expertise and experience.

Professionals providing those specific early interventions that have the highest potential for unintended harm (e.g., mass education via media outlets, psychological triage, leadership consultations, interventions that rely upon detailed recall of traumatic experiences) should be selected according to the high degree of training, expertise, accountability and responsibility required for the conduct of these early interventions.

Mental health professionals and others sanctioned to provide early interventions should avail themselves of high quality, empirically defensible training that confers competence in responding to major incidents and disasters. Organizations with experience and expertise in providing such responses should collaborate to provide this form of training.

Training should also incorporate content specific to incidents of mass violence, disasters and terrorism, including the organizational, procedural, emotional and environmental aspects these give rise to .

These specialist education, training and certification programs should be developed so as to be sanctioned or validated by appropriate professional bodies and organizations. This assures quality standards that are in the interest of service users and providers as well as the organizations that employ such staff (see attached appendix for example of training curriculum).

7. RESEARCH AND PROGRAM EVALUATION

Research and program evaluations are critically important components in advancing our understanding of and ability to provide effective early interventions.

The scientific community has an obligation to examine the relative effectiveness of early interventions that seek to reduce adverse outcomes and foster positive adaptations following major incidents and disasters.

A national strategy should be developed to ensure that adequate resources are available for systematic data collection, evaluation and research to be carried out before, during and after major incidents and disasters.

When the optimal forms of intervention are unknown, there is an ethical duty to do scientifically valid research to improve prevention, assessment, intervention and treatment.

Efforts and initiatives that document and describe what is done, by whom and to what end are currently inadequate and can be misleading. Major incident and disaster plans should give consideration to the best methods available for systematic data collection, evaluation, and research at each stage of early intervention.

These systematic evaluation activities should be planned and carried out in conjunction with those identified bodies that are responsible for organizing and delivering early interventions following major incidents and disasters.

Efforts should be made to facilitate collaboration between federal, state and local authorities responsible for funding, planning, delivering and assessing the impact of early interventions so as to facilitate systematic data collection, evaluation and research in this field.

A standard taxonomy (categorization) and terminology needs to be developed for program evaluations and research protocols. This helps identify and operationalize: (a) the potentially most significant psychological variables in the nature of mass violence attacks or disasters; (b) the post-event physical and psychosocial (recovery) environment; (c) subgroups of affected population including responders; (d) the mental health interventions provided, and; (e) the characteristics of those deemed the most appropriate providers of early interventions.

A strategy should be developed for informing the broader research community (including Institutional Review Boards (IRBs)), of the necessity to conduct rigorous research on sensitive topics.

Given the unplanned nature of most mass violence and disaster situations, as well as the logistic difficulties of carrying out systematic data collection in these situations, it may be the case that investigations into early interventions following mass violence and disasters require new mechanisms for proposing and funding this type of research.

Research should be done on which specific change elements of early interventions are most efficacious.

8. ETHICAL ISSUES

There is an ethical duty to conduct scientifically valid research to improve prevention, assessment, early intervention and treatment to enhance outcomes achieved by such forms of help and support.

The IOM, in collaboration with the Office of Human Research Protections (OHRP), should develop a strategy for educating the broader research community (including Institutional Review Boards), about the ethical necessity of conducting rigorous research on sensitive topics related to mass violence and trauma.

Early intervention policies should be based on empirically defensible and evidence-based practices. An ethical duty exists to discourage the use of ineffective or unsafe techniques.

9. KEY QUESTIONS TO ADDRESS WITHIN THE FIELD OF EARLY INTERVENTION

What is the demonstrable impact of public education initiatives on levels of knowledge, attitudes and behaviors evinced for those who have to live with endemic stress associated with on-going threats to safety and security?

Does “just in time” training for 1st responders reduce the risk of adverse MH outcomes? (Just in time training refers to training provided on site for responders during a major incident and disasters).

How feasible are RCTs with existing and novel early interventions (not placebo controls) involving high-risk traumatized cohorts? And how acceptable would they be to such potential research subjects?

To what extent can creative naturalistic experimental designs be employed to examine the relative benefits of existing early interventions?

Once a standard taxonomy (categorization) and terminology for early intervention has been developed for evaluations and research protocols, systematic investigations might address the following:

- How should the taxonomy be structured hierarchically so that it can be expanded to include new variables that will be discovered.
- How should the taxonomy be distributed through multiple authorities and agencies to care providers as well as to researchers?
- How should the taxonomy be used to assure quality and sufficient consistency to enable efficient automated data processing and meta-analysis across many program evaluations and controlled studies of early intervention that incorporate many years of data collection and follow-up?

Can research establish the extent to which screening during the first few weeks following a major incident and disaster may in itself be an effective strategy or intervention for reducing the risk of new onset or exacerbation of pre-existing psychopathology ?

Can screening produce harm in some individuals exposed to trauma? If so, what is the nature and extent of such harm (i.e., being used for purposes not intended by the investigators)? And, is the risk of such harm offset by the risk of failing to utilize screening instruments to identify those at high risk for negative outcomes?

What should be included in statements made to trauma survivors from whom informed consent is being sought to participate in screening, early intervention, follow up and treatment research?

What is best practice for seeking to obtain informed consent for acute interventions following mass violence? Do occasions arise when obtaining consent can (e.g., education on biopsychosocial reactions) induce negative effects?

What are the ethical issues involved in false positives in screenings?

Is it ethical to screen for conditions if access to care is not provided?

Lists of ethical issues relating to research in mental health interventions post mass violence should be formulated in order to assist IRBs in evaluating these protocols for use with humans. This list should also identify relevant bodies and organizations that have the skills/stature to make such recommendations.

What are the distinct and different ethical implications for Level I and Level II studies in the wake of mass violence interventions?

What are the ethical issues introduced by the widespread use of unproven interventions?

How does one balance demonstrable clinical demand and the desire to provide an intervention in the face of inadequacies in our current empirical evidence-based knowledge on effective early interventions for trauma?

What ethical issues arise from the shifts in professional boundaries (professional setting, physical and psychological objectivity with the client, etc.) in the context of early interventions?

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APPENDIX A: KEY COMPONENTS OF EARLY INTERVENTION

Some of these components will be provided by mental health professionals (MH) whilst others have components with mental health implications but will be provided by other service providers.

a) Basic Needs

- Safety/Security/Survival
- Food and Shelter
- Orientation
- Communication with family, friends and community
- Assess the environment for ongoing threat/toxin

b) Psychological First Aid

- Support for those who are most distressed
- Keep families together and facilitate reunion with loved ones
- Provide information, foster communication and education
- Protect survivors from further harm
- Reduce physiological arousal

c) Needs Assessment

Assess current status, how well needs addressed, recovery environment, what additional interventions needed for:

- Group
- Population
- Individual

d) Monitoring the recovery environment

- Observe and listen to those most affected
- Monitor the environment for toxins and stressors
- Monitor past and ongoing threats
- Monitor services that are being provided

e) Outreach and Information Dissemination

- “Therapy by walking around”
- Using established community structures
- Flyers
- Websites
- Media coverage

f) Technical Assistance, Consultation and Training

Improve capacity of organizations and caregivers to provide what is needed to re-establish community structure, foster family recovery/resilience, and safeguard the community

Provided to:

- relevant organizations
- other caregivers and responders
- leaders

g) Fostering Resilience/Recovery

Social interactions
Coping skills training
Education about stress response, traumatic reminders, coping, normal vs. abnormal functioning, risk factors, services
Group and family interventions
Fostering natural social support
Looking after the bereaved
Repair organizational fabric (i.e., operational debriefing, when standard procedure)

h) Triage

Clinical Assessment
Referral when indicated
Identify the vulnerable, high risk individuals and groups
Emergency hospitalization

i) Treatment

Reduce or ameliorate symptoms or improve functioning via:
Individual, family and group psychotherapy
Pharmacotherapy
Spiritual support
Short-term or long-term hospitalization

APPENDIX B: GLOSSARY OF TERMS

Operational debriefing is a routine organizational mechanism for group review of the experience, “putting the pieces together” to form a factual account into a cohesive picture, and facilitating lessons learned.

Psychological debriefing is the describing of an event which includes education and review processes with a positive focus on resilience and coping strategies versus detailed review of emotional reactions.

Critical Incident Stress Debriefing (CISD) refers to the "Mitchell model" (Mitchell and Everly, 1996) 7-phase, structured group discussion, usually provided 1 to 10 days post crisis, and designed to mitigate acute symptoms, assess the need for follow-up, and if possible provide a sense of post-crisis psychological closure. The phases include:

- Preparation
- Introduction
- Discussion of Facts
- Discussion of Thoughts
- Discussion of Feelings/Sensations
- Education about Responses and Coping Strategies
- Re-Entry

Defusing This is a 3-phase, structured one-to-one or small-group discussion provided within hours of a crisis for purposes of assessment, triaging, and acute symptom mitigation.

APPENDIX C: GUIDELINES FOR TIMING OF INTERVENTIONS

Phase	Pre-incident	Impact (0-48 hours)	Rescue (0-1 week)	Recovery (1-4 weeks)	Return to Life (2 weeks – 2 years)
Goals	Preparation, improve coping	Survival, Communication	Adjustment	Appraisal/ planning	Re-integration
Behavior	Preparation vs. denial	Fight/flight, freeze, surrender, etc.	Resilience vs. exhaustion	Grief, reappraisal, intrusive memories, narrative formation	Adjustment vs. phobias, avoidance, depression, PTSD, etc.
Role of all helpers	Prepare, train, gain knowledge	Rescue, Protect	Orientation, Provision of needs	Responsiveness, Sensitivity	Continuity of assistance
Role of Mental Health professionals	<p><u>Prepare</u> Train</p> <p>Gain knowledge</p> <p>Collaborate</p> <p>Inform and influence policy</p> <p>Set structures for rapid assistance</p>	<p><u>Basic Needs></u> Establish Safety/Security/ Survival</p> <p>Ensure Food and Shelter</p> <p>Provide Orientation</p> <p>Facilitate communication with family, friends and community</p> <p>Assess the environment for ongoing threat/toxin</p> <p><u>Psychological First Aid></u> Support and “presence” for those who are most distressed</p> <p>Keep families together and facilitate reunion with loved ones</p> <p>Provide information, foster communication</p>	<p><u>Needs Assessment></u> Assess current status, how well needs addressed, recovery environment, what additional interventions needed for: 1. Group 2. Population 3. Individual</p> <p><u>Triage></u> Clinical Assessment</p> <p>Refer when indicated</p> <p>Identify the vulnerable, high risk individuals and groups</p> <p>Emergency hospitalization</p> <p><u>Outreach and Information Dissemination ></u> Make contact with and identify people who have not requested services (i.e.,</p>	<p><u>Monitor the recovery environment></u> Observe and listen to those most affected</p> <p>Monitor the environment for toxins</p> <p>Monitor past and ongoing threats</p> <p>Monitor services that are being provided</p>	<p><u>Treatment</u> Reduce or ameliorate symptoms or improve functioning via:</p> <p>Individual, family and group psychotherapy</p> <p>Pharmacotherapy</p> <p>Spiritual support</p> <p>Short-term or long-term hospitalization</p> <p>Operational debriefings, when this is standing procedure in responder organizations</p>

		<p>and education (i.e., services)</p> <p>Protect survivors from further harm</p> <p>Reduce physiological arousal</p>	<p>“Therapy by walking around”</p> <p>Inform people about different services, coping, recovery process, etc. (i.e., by using established community structures, flyers, websites)</p> <p><u>Technical Assistance, Consultation and Training</u></p> <p>Improve capacity of organizations and caregivers to provide what is needed to reestablish community structure, foster family recovery/resilience, and safeguard the community</p> <p>Provided to:</p> <ul style="list-style-type: none"> • relevant organizations • other caregivers and responders • leaders <p><u>Fostering Resilience/Recovery</u></p> <p>Social interactions</p> <p>Coping skills training</p> <p>Education about: stress response, traumatic</p>		
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			reminders, coping, normal vs. abnormal functioning, risk factors, services Group and family support Fostering natural social support Looking after the bereaved Repair organizational fabric Spiritual Support		
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≥ = occurs in this and later phases

APPENDIX D: APPROPRIATE TRAINING OF THE EARLY INTERVENTION WORKFORCE

BACKGROUND CONSIDERATIONS

Potential Audiences:

Different forms of early intervention require different sets of skills, training, and background knowledge. Besides **mental health practitioners** who are key professionals in this respect, many early intervention and follow-up activities with trauma survivors may have to be delivered by those not specifically pre-trained in early intervention. They may include:

- paraprofessionals
- community volunteers
- medical professionals, including primary care practitioners and pediatrician/family practice
- disaster responders
- clergy
- school personnel
- staff of paraprofessional helping organizations such as Alcoholics Anonymous

Core Training Modules:

1. Because much early intervention consists of providing emotional and practical support, help in reconnecting with family or friends, information about services available etc can be achieved by building on the existing **communication, listening, and empathy skills plus other personal qualities of helpers.**

2. General training in **mental health aspects of trauma** should be delivered not only to mental health professionals involved in providing emergency mental health support, but also, as appropriate, to others who will respond to those recently traumatized. See above list. It is also important that such training be made available to emergency responders (e.g., firemen, police, hospital trauma center personnel, coroners) to help these staff groups understand the mental health implications of their work and foster appropriate competencies.

3. The need to **educate trauma survivors** and the communities that provide their recovery environment is widely accepted, and should be a part of any training program. There is general agreement that such education should inform survivors about:

- the nature of traumatic stress reactions
- the “normalization” of traumatic stress responses
- risks factors associated with more serious problems, without creating expectation of chronicity
- ways of coping and mastering the effects of major incidents and disasters

- availability of services available in the aftermath of major incidents and disasters (including mental health counseling)
- timing and the processes of self-referral for specialist help

While in this curriculum, providing education does not include the same type of specialized training required to deliver, for example, exposure therapy (see below), it is not clear what training about ways to educate trauma survivors can realistically achieve.

It is assumed that those mental health workers who have an understanding of disasters and their consequences can pass on this information to survivors and their closest relatives. Because of the physical and psychological state of survivors in the early aftermath of major incidents and disasters it is probably true that the content of preventive education programs is not learned in a systematic and deliberate fashion. It is therefore important to train workers to appreciate the importance both of the content and manner of communicating **effectively and systematically**.

There are potential risks of education efforts that must be carefully addressed, including:

- Dispensing erroneous information, current fad or uninformed opinion as proven fact
- Compounding social stigmatization of those with more symptoms
- Causing "reverse stigmatization" and guilt-- "If you don't have these symptoms, there's something bad and unfeeling about you."
- Using vocabulary and concepts unfamiliar to the specific audience, especially technical terms and jargon that have unintended negative effects. One script does not suit all audiences.
- Clinician presenters unconsciously over-pathologizing and focusing on therapy and disability compensation, rather than facilitating natural supports and resiliency.

Specialized Modules:

More evidenced-based, **specialized interventions** targeted at those who are at significant risk of developing PTSD and other post-trauma problems require specialized skills. For example, the cognitive-behavioral early interventions noted above require practitioners to deliver structured training in breathing and relaxation, imaginal and *in vivo* exposure therapy, and cognitive restructuring. This means that mental health professionals will be the most appropriate group to deliver these interventions.

Two of the best-validated treatment elements for PTSD and depression are direct therapeutic exposure and cognitive restructuring. These are not systematically taught in graduate schools nor is it wise to assume they can be delivered by any mental health professionals whose skills repertoire may not be in keeping with those required for early intervention after major incidents and trauma. Additionally, there are important caveats

to delivering these interventions with the bereaved and recently traumatized. This means that specialized training will be necessary to supplement mental health professionals' existing skill and knowledge base.

Other forms of specialized training is also likely to be required to assist workers involved in the delivery interventions to minimize the effects of trauma. This may include:

- screening and identification of risk factors for chronic post-trauma problems
- providing support during and after death notification
- working with traumatized children
- working with traumatic bereavement
- working with special populations such as emergency services workers

In addition to interventions targeting post-traumatic stress responses, follow-up service providers should be alert to and trained to identify and intervene with **other common problems that come to light in the aftermath of trauma**. For example, alcohol and substance abuse are highly prevalent among patients admitted to surgical trauma units (Soderstrom et al. 1997). Many patients requiring early intervention to prevent development of PTSD may already have established patterns of substance abuse. Comprehensive provision therefore requires services to address both sets of problems.

Broadly, the most important and challenging part of follow-up training concerns which interventions to provide in the aftermath of traumatic events. This is because specific skills must be taught and because currently available research literature does not give definitive signposts as to what these interventions should be. However, early post-trauma interventions are now receiving greatly increased research attention and much relevant evidence should be forthcoming during the next few years. This means that it will be important to design systems for **periodically updating and changing the content of early intervention training**.

In a recent review of training in mental health response to disaster and community violence Young, Ruzek and Pivar (2001), offered a set of recommendations for improvements in training. These training recommendations apply to the context of early intervention as well:

RECOMMENDED BASIC CONTENTS OF TRAINING

Nature and Effects of Disaster and Community Violence

Existing Response Structures and Processes:

- Federal Response Plan, Disaster Agencies, and Organizational Relationships
- Mental Health Response in the Disaster Context
- The Ethics of DMH/CV Response
- What to Expect

- Grant application

Disaster Mental Health Resources

Evidence-Based Interventions: Content and Skills:

- General Goals of Intervention
- On-Scene Support and Psychological First Aid
- Survivor Education
- Social Support
- Debriefing and Defusing
- Environmental Interventions
- Pharmacotherapy
- Referral to Mental Health Services
- Community Organization and Self-Help Group Interventions
- Operational debriefing in responder organizations

Considerations in Intervention:

- Matching of Intervention and Phase of Disaster
- Matching of Intervention and Setting
- Matching of Intervention and Survivor

High-Risk Groups:

- Identification of Those At-Risk for Mental Health Problems
- Children
- Bereaved Survivors
- Elderly Survivors
- Survivors with Prior Mental Health Problems

Other Types of Disaster:

- Community Violence

Outreach

Cultural Issues

Mass Media

Disaster Worker Stress

Leading and Managing Disaster/Community Violence Mental Health

Additional Content Recommendations:

Utilize Existing Literature to Inform Training:

- Link training content (e.g., discussion of acute stress reactions) to existing empirical research.
- Devote more attention to educating workers about research-based risk factors for chronic mental health problems following disaster or community violence exposure.
- Train workers to use awareness of risk factors as well as formal screening tools to select those requiring referral to more intensive services and energetic follow-up.
- Help workers understand the changed settings and dynamics for post-disaster intervention:
 - The different personal responses and dynamics or interpersonal relationships (i.e., lowered defensiveness, heightened neediness, affiliative behaviour, need for comforting).
 - Increasing the capacity to work in a chaotic environment, without the protection of usual roles and office settings
 - Conducting interventions in environments of need such as shelters, temporary or crowded relief centers, morgues and so forth.

Develop Educational Materials:

- Materials focused on training survivors and emergency responders to support one another and teaching parents how to talk with their children about the event and its consequences.
- A comprehensive listing of available disaster mental health training resources, along with recommendations identifying the most useful materials.
- Make sanctioned training materials and handouts easily available to practitioners, via web and CD technology.

Develop Specialized Training Modules for Mental Health and Medical Practitioners:

- Providing consultation to disaster response leaders, team leaders and workers, and other members of the community, on mental health aspects of mass violence.
- When and how to refer to more intensive mental health services.
- Effective didactic presentation of education to survivor groups and emergency responders.
- Systems for follow-up of high-risk survivors.

- Providing DMH services to children of different ages.
- Identifying survivors presenting both initially and at later times:
 - The settings where those at highest risk for continuing psychological problems are likely to be encountered.
 - Integrating mental health care into settings where emergency medical treatment is provided.
 - Evidence-based assessment methods for clergy, primary care providers, and mental health professionals.
- Specific evidence-based interventions such as:
 - brief cognitive-behavioral methods designed to prevent PTSD
 - bereavement support and treatment of traumatic bereavement
 - psychotropic medications in managing acute stress reactions
 - stress management (e.g., relaxation, breathing)
 - coping skills training (e.g., problem-solving, giving and receiving help, mutual support communication skills for families and neighbors, assertion training)
 - relapse prevention
 - brief interventions designed to prevent alcohol and prescription medicine abuse
- Mental health challenges associated with biological or chemical disasters, terrorism, or use of weapons of mass destruction.
- Integrating counseling with welfare response and practical assistance
- Secondary traumatization, burnout, and vicarious traumatization, and the progressive stepdown that is needed for return to usual duties
- Community Interventions:

- Assessment of environments where survivors and emergency responders are congregated and strategies for improving those environments.
 - The effects of disaster and violence on the functioning of larger groups of individuals, such as families, communities, and workplaces, and strategic interventions (e.g., assessment, consultation, support programs) for such groups.
 - Community organization and collaboration with self-help organizations.
 - The role of media in the aftermath of disaster and criminal violence along with practical advice for managing common aspects of media relations.
- Primary Care Practitioners:
 - Assessment and treatment of traumatic stress and loss issues, at the primary care level
 - Executive Skills: Creating an Effective Disaster Mental Health (DMH) Team:
 - Forming, operating, and maintaining a DMH team
 - Liason with community, state, and federal leaders
 - Navigating the grant application process
 - Identifying potential needs
 - Ensuring qualified and trained professionals are provided at appropriate points and settings of the post disaster response
 - Oversight and supervision of more general support workers
 - Vetting the multiplicity of counsellors, debriefers and others who present to offer help.
 - Establishing a legitimate role and place
 - Providing clear information to other post disaster workforce of their roles, with clear delineation of what they can offer

- Outreach and follow-up (i.e., use of media, providing brochures, cards etc with contact details)
- Clinical issues and responsibilities as professionals, including documentation and review
- Setting in place the framework for follow-up
- Clear liaison with local and neighbouring agencies of response and local care systems.
- Effectively supporting the caregivers (i.e., preventing secondary traumatization, burnout, vicarious traumatization)
- Ethical issues associated with DMH service delivery.

Improving the Process of Disaster Mental Health Training:

- Provide training in language that is readily understood, to avoid professional jargon and the pathologizing of normal response.
- Develop more “hands-on” training approaches, that provide trainees with multiple opportunities to observe, practice, and receive coaching as they attempt to employ various helping skills, by increasing use of:
 - role-play exercises
 - sample scripts that illustrate skills
 - narratives describing real-world disaster scenarios)
 - interactive CD-ROM video materials
- Increase use of videotapes showing aspects of DMH care in order to give trainees a sense of what really takes place at disaster sites and settings, what they may see, and how these settings typically “look and feel.”
- Move toward greater specification of training procedures, and systematization of delivery of training.
- Develop systems for continuing education of DMH workers.
- Develop methods to evaluate the effectiveness and perceived usefulness of DMH training procedures.

APPENDIX E: ADDITIONS AND DISSENTING OPINIONS FROM THE CONSENSUS CONFERENCE

I. Debriefing:

Dr. George Everly:

1) The term "psychological debriefing" has lost any sense of definitive meaning. It is recommended that the term not be used in the psychological context without a qualified explanation so that the reader operationally understands the context within which the term is used. Earlier in the proceedings, it was unanimously voted to remove the term "debriefing" from the extant psychological nomenclature. Nevertheless, the group subsequently contradicted its earlier recommendation and used the term "psychological debriefing" with an accompanying adverse finding. Therefore, it is recommended that the term "psychological debriefing" be removed from the recommendations section while allowing the statement regarding individual counseling with medical patients (as reviewed in the Cochrane Review) to stand. Having made the aforementioned statement, it should be noted that the literature review committee did identify two RCTs (Deahl et al., 2000; Campfield & Hills, 2001) which provided evidence which may be seen as initial support for the structured and manualized group crisis intervention Critical Incident Stress Debriefing (CISD).

2) The conclusion that "psychological debriefing" may be harmful engenders concern. Once again, the term "psychological debriefing" has no operational meaning and serves only to further confound the literature in the absence of an operational definition. Furthermore, the two RCTs upon which the conclusion is based are suspect regarding both internal and external validity. Both RCTs (Bisson et al., 1997; Hobbs et al., 1996, with follow-up by Mayou et al., 2000) failed to achieve equivalent group membership at pre-test ("debriefed" groups had more severe injuries in both studies). The pre-test differences may have served to influence post intervention outcomes. Clearly, scrutiny of the manifest psychometric increases in the "debriefed" group within the Hobbs study reveals a statistically significant change that has no practical clinical relevance. The restricted range, lack of manifest variability, and subclinical scores (post intervention mean = 15.97; clinical significance is generally accepted in excess of 25) obtained by the patients in this study prevent a useful clinical conclusion, contrary to the conclusion reached by the authors.

3) Total adherence to RCTs as the sole source of evidence is in contradistinction to trends in the related field of psychotherapy research. As Seligman (Am. Psych. vol. 51, 1996) has noted, "But efficacy studies are not necessary, sufficient, or privileged over effectiveness studies in deciding whether treatment works" (p. 1077). We appear to be using a double standard for what we accept as evidence of psychotherapy outcome as opposed to what we accept as evidence in early intervention research. Flannery's (Flannery et al., Psychiatric Services, vol. 49, 1998) multicomponent crisis intervention system, while selected as one of the 10 best clinical programs in 1996 by the American Psychiatric Association, is, therefore, ignored from consideration due to its lack of RCTs.

4) Finally, while it seems clear at this point that there is insufficient RCT evidence to recommend "one off" crisis counseling with medical patients (see Cochrane Review), this finding has very little to do with the task of addressing the mental health needs of victims in the wake of a mass disaster such as the WTC terrorist attack. We must be sure to make note of the lack of RCT evidence which pertains to mass disasters.

Dr. Brett Litz:

There is no available evidence from RCTs to support the efficacy of CISD (critical incident stress debriefing) as an early preventative intervention. CISD may assist with group cohesion, morale and other important variables that have not been demonstrated empirically. Further research may establish whether CISD promotes favorable outcomes and if so, what those outcomes might be.

Reference:

Litz, B.T., Gray, M.J., Bryant, R., and Adler, A.B. (in press). Early Intervention for Trauma: Current Status and Future Directions. *Clinical Psychology: Science and Practice*.

COL James Stokes:

Those conducting organizational debriefings should consider the potential long-term behavioral and mental health effects of their debriefing techniques, and should conduct long-term program evaluation using scientific methods.

"Critical incident stress debriefing" should only be used in the organizational context of pre-existing teams that have experienced traumatic mission events, debriefed according to protocol with the intent of sustaining capability to continue operations.

II. EMDR:

COL James Stokes:

The Consensus Conference and its academic authorities should advocate collaborative (collegial) RCTs by skilled proponent of both EMDR and the best CBT protocols. The RCT trials should be actively assisted and monitored by impartial research experts, to determine whether EMDR's claims for significant advantage over other treatments (or vice versa) are empirically substantiated in some or all patient populations. At this stage in the published research, only proof that EMDR is inferior to some other treatments in all patient populations and conditions could establish that it is never "a" treatment of choice. If it does work as well as (or faster than?) other scientifically validated treatments in some (but not all) patient categories, it may be "a" treatment of choice" for a variety of reasons.

Establishing how EMDR works, provided that it does work and is safe, is worthy of dismantling studies (as Cahill and Servan-Schreiber discuss, and EMDR proponents as well as critics are doing). It is irrelevant to whether EMDR should be used. We don't know why ECT works, but it is still "a" treatment of choice for severe major depression and catatonia, and may be "the" treatment of choice for some patient subtypes. To quote Servan-Schreiber (pp.39), "... Shapiro's main contribution to the treatment of PTSD [could] be how she has articulated many available elements of good therapy into a simple and effective protocol that is more acceptable to patients and easier for therapists to learn and use than other forms of treatment." Only empirical research can determine if that is true.

References:

- 1) Point/Counterpoint in PSYCHIATRIC TIMES, Jul 2000
pp. 36-40, Servan-Schreiber, D., "EMDR: Is Psychiatry Missing the Point."
pp. 41-50, Cahill, S.P.. "Evaluating EMDR in Treating PTSD."
- 2) Powers, K.G., "A Controlled Comparison of EMDR versus Exposure plus Cognitive Restructuring versus Waiting List in the Treatment of PTSD,"
presentation No.034 at the European Society of Traumatic Stress Studies
meeting, Edinburgh, May 2001