First Aid to Staff
Northeast Florida State Hospital
Staff Debriefing
Southern States Psychiatric Hospital Association and the National Association of State Mental Health Program Directors Forensic Division Joint Conference
Wednesday October 5, 2016

JENNIFER SLUSARZ-CONROY, PSY.D., ASSISTANT HOSPITAL ADMINISTRATOR – RECOVERY SERVICES
CIANA MICKOLUS, PSY.D., PSYCHOLOGIST
Outline

- History
- Definition of a “critical incident”
- Reactions to a “critical incident”
- Mitchell Model: Critical Incident Stress Debriefing
- Theory
- Research
- NEFSH process
- Preliminary NEFSH results
History

- WWI and WWII
- Israeli Defense Forces - 1967 war
- Dr. Jeffery Mitchell - 1974
  - Critical Incident Stress Debriefings (1983)

High risk occupational groups

- Firefighters
- Law enforcement officers
- Emergency medical workers
- Disaster response personnel
- Emergency dispatchers
- Public safety personnel

Everly & Mitchell (1995)
History

- Expansion
  - Military
  - Clergy
  - School systems
  - Banking industry
  - Mining
  - Oil discovery and refining operations
  - Lifeguard services
  - Employee assistance programs
Organizations whom Dr. Mitchell has interviewed, consulted, or trained

United States Marshals Service
Hershey Medical Center
American Psychological Association
Federal Bureau of Investigation
Department of Homeland Security
Federal Emergency Management Agency
United States Army
United States Air Force
United States Marine Corps
United States Navy
United States Coast Guard
Bureau of Alcohol, Tobacco and Fire Arms
United States Secret Service
United Nations
Montgomery County Fire Department
Los Angeles County Fire Department
Singapore Department of Corrections
Swedish National Police
Shell Oil Company
Critical Incident Stress Management Foundation of Australia
German Army
German Air Force
Austrian Red Cross
Portuguese National Guard
Argentina Federal Police
Kuwait Department of Social Support
Miami, Florida Police Department
Riverside County California
Humbolt County California
Jacksonville, Florida Fire Department
Virginia Department of Health
Chicago Airport Authority
Anchorage Police Department
Norwegian Air Force
German Air Traffic Control
Portuguese Air Traffic Control
United States Federal Aviation Administration
Staff Care, Belfast, Northern Ireland
American College of Emergency Physicians
International Association of Fire Fighters
International Association of Fire Chiefs
International Association of Chiefs of Police
Alberta Safety Services
Boston Emergency Medical Services
European Psychological Society
Victory Memorial Hospital, Waukegan Illinois
Zero to Three, Washington, DC
Sedgewick County Police Department
New York State Fire Chiefs Association
Texas Department of Public Safety

Downtown Hospital of New York
Arkansas State Police
Kansas State Police
European Society for Traumatic Stress Studies
Center for Crisis Psychology, Bergen, Norway
International Society for Traumatic Stress Studies
American Airlines
Delta Air Lines
Southwest Airlines
United Airlines
Air Alaska
Canadian Armed Forces
National Association of Search and Rescue
Aloha Airlines

http://www.nc-cm.org/biojeffreymitchell.htm
Critical Incident Stress Management

“A comprehensive, systematic and integrated multi-tactic crisis intervention approach”

- Pre-crisis preparation
- Individual counseling
- Demobilization (brief large-group discussions; mass disasters)
- Defusing (brief small-group discussions)
- Debriefing (group discussion)
- Family support interventions
- Follow up and referrals for psychological assessment/treatment

Definition: Critical Incident

“**Traumatic**, unexpected, and a serious threat to the individual’s well-being; contains an element of loss; and involves disruption of the individual’s values or assumptions about the environment.”

Should be defined “not in terms of the event, but rather in terms of the **impact it has on the individual.**”

NEFSH Definition: Critical Incident

A significant traumatic event: “exposure to actual or threatened death, serious injury, or sexual violence” through directly experiencing the event, witnessing the event, learning that the event occurred to someone close, or experiencing repeated/extreme exposure to details of the event.

Examples include: resident death, assault on an employee or resident, extreme self-injurious behavior by a resident, etc. Examples may also include unusual or critical events, as defined by OP 09-00-03, Unusual Incident Reporting, Prevention, and Investigation.
What happens after someone experiences a critical incident?

- Immediate Responses
  - Muscular tremors
  - Nausea
  - Hyperventilation
  - Faintness
  - Sweating
  - Perceptual Distortions

- Minutes or Hours Later
  - Shock
  - Fear
  - Denial
  - Anger
  - Numbing
  - General feeling of unreality

Bohl (1995)
What happens after someone experiences a critical incident?

- Delayed Reactions
  - Grief
  - Intrusive thoughts
  - Flashbacks
  - Nightmares
  - Poor sleep
  - Depression
  - Emotional withdrawal
  - Anxiety
  - Guilt
  - Paranoia
  - Sexual dysfunction
  - Headaches
  - Stomach aches

Bohl (1995)
What happens if symptoms are left unaddressed?

- May resolve within weeks or months
- Or may lead to:
  - Anger
  - Hostility
  - Irritability
  - Fatigue
  - Inability to concentrate
  - Loss of self-confidence
  - Increased use of drugs/alcohol/eating
  - Poor work performance
  - Instability in relationships
  - Burnout
  - PTSD
  - Suicide

Bohl (1995)
“A specific, seven-phase, small group, supportive crisis intervention process...a crisis-focused discussion of a traumatic event”

- “Psychological first aid”

- Objectives:
  - Decrease the impact of a traumatic event
  - Aid in normal recovery from the traumatic event
  - Screen employees who may benefit from further professional care
What it’s not

- Therapy
- A therapy substitute
- An investigation
- A stand-alone process

Mitchell 2014
Videos

- https://www.youtube.com/watch?v=515zaAiiEOk
- Navy:
  https://www.youtube.com/watch?v=VxGnDPM0InY
The Mitchell Model of CISD

- 24 to 72 hours post-incident
- 1 to 3 hours long
- Group members
  - Must not be currently involved in the incident
  - About the same level of exposure
  - Psychologically ready to participate
- 7-phase discussion
- Led by a team of 2-4 people, depending on the group size (one team member for every 5 to 7 people)
  - One mental health professional
  - One “peer support personnel”
Phases of the Mitchell Model

- Phase 1: Introduction
- Phase 2: Facts
- Phase 3: Thoughts
- Phase 4: Reactions
- Phase 5: Symptoms
- Phase 6: Teaching
- Phase 7: Wrap Up
Example: the ER

https://www.youtube.com/watch?v=m0a-KR4pKik
Theory: Mechanisms of Action

- Early intervention
- Catharsis and verbalization
- Structure
- Group support (Yalom)
- Peer support
- Allows for follow up

Everly, Flannery & Mitchell (2000); Mitchell & Everly (1995); Yalom (2005)
Supporting Research

- Decrease in severity and number of PTSD symptoms
- Decrease in anxiety and depression symptoms
- Reduction in sick leave, turnover, and early retirement
- Decreased suicide rate
- Reduction in alcohol abuse
- Decrease in stress
- Decrease in anger
- Enhanced self-esteem, emotional well-being
- Staff reported better coping skills

Contrary Views

- Neutral or Negative
  - No preventative effect
  - No reduction in symptoms
  - Possible postponing of symptoms
  - Higher levels of stress

Why NEFSH? Why now?

- Assaults
- Resident death
- Low morale
At NEFSH: Before a critical incident

- Pre-crisis Preparation (New Employee Orientation)
  - Training on general stress management and the CISD process
At NEFSH: After a critical incident

- Within one business day, UTRDs (or designee) will e-mail or call the Director of Psychology
  - Describe the incident
  - Provide a list of staff involved

- All staff members involved/affected by the incident will meet
  - Within 24 to 48 hours post-incident
  - With the Director or Psychology or designee

- Other staff who were directly or indirectly impacted by the event may attend with the permission of the Director of Psychology
  - Treatment team members
  - Unit directors
  - Supervisors
At NEFSH: After the debriefing

- Follow-up and Referrals
- Anonymous evaluation form of the debriefing
  - Evaluations are maintained by the Psychology Department
  - Data is compiled and analyzed
NEFSH Data

- N = 12 Staff completed and returned anonymous surveys
- 4 separate events debriefed
- “What did you like about the meeting”
  - Helpful
  - Everyone was included; not just the ward it pertained to
  - We come together as a group
  - Being able to express your feelings
  - I felt comfortable enough to talk to her
- Asked “What would you change about the meeting?”
  - All respondents answered “nothing” or “N/A”
## Preliminary NEFSH Results

### Critical Incident Stress Debriefing Survey Data:

<table>
<thead>
<tr>
<th>Questions (Response scale 0 - 10)</th>
<th>Response Averages:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How did you feel before this meeting?</td>
<td>Scared: 2.00</td>
</tr>
<tr>
<td></td>
<td>Angry: 2.10</td>
</tr>
<tr>
<td></td>
<td>Anxious: 1.70</td>
</tr>
<tr>
<td></td>
<td>Depressed: 1.50</td>
</tr>
<tr>
<td></td>
<td>Other: 0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Questions (Response scale 0 - 10)</th>
<th>Rating Averages:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. How do you feel after this meeting?</td>
<td>Scared: 0.50</td>
</tr>
<tr>
<td></td>
<td>Angry: 1.60</td>
</tr>
<tr>
<td></td>
<td>Anxious: 1.00</td>
</tr>
<tr>
<td></td>
<td>Depressed: 1.00</td>
</tr>
<tr>
<td></td>
<td>Other: 1.00</td>
</tr>
</tbody>
</table>
Conclusions

- Preliminary data suggests staff feel the process is helpful
- Early in the process, unclear if the debriefings will lead to less staff turnover and/or illness
- Desired outcome:
  - Staff feel supported and validated
  - Staff recover quickly from the impact of a traumatic event
  - Reduction in turnover and increase in morale
References


