Guideline for Early Interventions

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ABSTRACT

In the Netherlands, acute psychological assistance, also referred to as 'early interventions' or 'debriefing', is offered following shocking events. These may be large scale disasters or calamities, but also military deployment and individual incidents.

During the last years, the demand for early interventions has been increasing. International literature has shown that the psychosocial effects of disaster and military deployment may last for years. Therefore psychosocial care is essential, but it may be questioned if those affected benefit from early interventions that are offered nowadays.

In scientific literature there is growing consensus that single session debriefing is not effective and even may do harm. Despite this unequivocal conclusion, single session debriefing is still practised. Furthermore, experts do not agree on the appropriate moment when early interventions should take place, what disciplines are best equipped to do the job and what methodology should be followed.

Until now, interpretation, practice and possibly the follow-up of early interventions depend on the view of organisations, individual careproviders and various interests. As a result of this, early interventions are offered in many ways, and those affected are not always treated in accordance with best-practices.

In short, on the shop-floor and in the theatre, careproviders have doubts on early interventions. Therefore, it is crucial to make evidence based recommendations.

The Impact Foundation develops, in collaboration with the Trimbos institute for mental health and subsidised by the Dutch Ministry of Health, Welfare and Sports, an evidence based guideline for early interventions following disaster, terrorism and other schocking events. Based on the latest insights from literature and daily practice, this guideline addresses what works, what doesn't work and what the gaps are in our knowledge.

1.0 MILITARY DEPLOYMENT

The world has become a global village. Military operations take place under the eye of the world and are surrounded by high political attention. International missions far exceed frontiers and often aim at peace enforcing, peace keeping and post-war reconstruction. Participation in peace operations takes place in a broad and joint context and demands specially trained military personnel who are able to operate in unknown cultures and who are faced with challenges which they have never encountered before. This is not an easy task which may imply significant risks.

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Military servicemen run risk to become (fatally) injured or wounded and a significant minority is prone to develop post-deployment mental disorders and symptoms.

During missions, many military are exposed to the gruesome effects of war. They may be confronted with violence, constant threat of attacks and shootings and they are at risk of their lives. Taking of hostages, torture, physical injuries and confrontation with humanitarian aspects such as misery of the local population may leave tracks.

2.0 POST-DEPLOYMENT SYMPTOMS

The vast majority of soldiers return home safe and healthy. Happily. They are often self-contented. They were able to do the duties they were trained for, they were given an opportunity to contribute to a safer world and they often have experienced bonding with colleagues. The reverse of the medal consists of a small, but significant part of military personnel who are faced with a great diversity of health problems. Up to nineteen percent of those returning from Afghanistan and Iraq reported mental health symptoms consistent with major depression, generalized anxiety and posttraumatic stress disorder (PTSD) (Hoge et al., 2006; Kang, 2005; Hoge et al., 2004).

Overall, about one of every five soldiers develops mental and/or medically (unexplained) post-deployment symptoms. (De Vries, 2006; De Vries et al., 2000).

In the nineties, the American and British army were confronted with larger groups of military servicemen, returning from the first Persian Gulf War, reporting ill health. They were dog-tired and suffered from a wide range of symptoms. In fact, these military experienced health complaints which are common in the general population. They suffered the same health problems although much more frequent as compared to civilians and military who were not sent to the Persian Gulf (Wessely., 2001). At that time, Dutch United Nations (UN) soldiers returned from deployment in Cambodia. Their health was likewise troublesome. Research showed that 17% of the servicemen suffered from severe fatigue. PTSD was observed in less than 2% (De Vries et al., 2002).

Post-deployment symptoms may be severe, persistent and chronic. A part of Gulf War and Cambodia veterans has significant complaints and is not able to get rid of them. Deployment also leaves tracks in the long-term. Twenty-five years after deployment in Lebanon, about 15% of Dutch UN veterans still reported impaired psychological well-being (Mouthaan et al., 2005).

Reporting of symptoms in servicemen and veterans has been a common phenomenon for ages (De Vries, 2001, Hyams et al., 1996). Since the American Civil War until recent military interventions in Iraq and Afghanistan, many examples of mental disorders and unexplained somatic symptoms are presented, all provided with their own names: e.g. effort syndrome, shell shock, combat fatigue, Agent Orange syndrome, Gulf War Syndrome and posttraumatic stress disorder.

3.0 EARLY INTERVENTIONS

It is hardly surprising that attempts have been made to prevent the negative side-effects of deployment. During the last two decades, the field of psychosocial care has evolved, both in the military and civilian setting. Many countries are developing post-deployment care and consequently the nature, content and perspectives on aftercare differ. In many countries, returned servicemen receive a medical evaluation including some kind of psychological screening. In some countries, returned soldiers are monitored by longitudinal questionnaires assessing health symptoms and psychological wellbeing.

Overall, both in the military and civilians, there is an increasing public demand for psychosocial efforts in the wake of military missions, large scale disasters or calamities, terrorist attacks and individual incidents.

It is usual practice that acute psychological assistance, also referred to as ‘early interventions’ or ‘debriefing’ is offered following shocking events. Although psychosocial care is essential, it may be questioned if those affected benefit from early interventions that are offered nowadays.

In scientific literature there is growing consensus that single session debriefing is not effective and even may do harm (Rose et al., 2005; Van Emmerik et al., 2002). Despite this unequivocal conclusion, single session debriefing is still practised. Furthermore, experts do not agree on the appropriate moment when early interventions should take place, what disciplines are best equipped to do the job and what methodology should be followed.

Until now, interpretation, practice and possibly the follow-up of early interventions depend on the view of organisations, individual care providers and various interests. As a result of this, early interventions are offered in many ways, and those affected are not always treated in accordance with best-practices.

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In 2001 the National Institute of Mental Health (NIMH) formulated expert consensus statements on early psychological interventions (box 1). This document highlights primarily what does not work, but is less concrete on what is effective. The National Institute of Clinical Excellence (NICE, 2005, box 2) gives practical recommendations on watchful waiting and trauma focused cognitive behavioural therapy in individuals who present with PTSD.

In the Netherlands, the Impact Foundation develops, in collaboration with the Trimbos institute for mental health and subsidised by the Dutch Ministry of Health, Welfare and Sports, an evidence based guideline for early interventions following disaster, terrorism and other shocking events. Based on the latest insights from literature and daily practice, this guideline addresses what works, what doesn’t work and what the gaps are in our knowledge. The Dutch guideline will be published late 2006.

Box 1. Early interventions: what works, what is effective?

Consensus statements NIMH, 2002

- A sensible working principle in the immediate post-incident phase is to expect normal recovery.
- Presuming clinically significant disorder in the early post-incident phase is inappropriate, except when there is a pre-existing condition.
- Participation of survivors of mass violence in early intervention session, whether administered to a group or individually, should be voluntary.
- The term "debriefing" should be used only to describe operational debriefings. Although operational debriefings can be described as "early interventions", they are done primarily for reasons other than preventing or reducing mental disorders.
- Early, brief, and focused psychotherapeutic intervention can reduce distress in bereaved spouses, parents and children.
- Selected cognitive behavioural approaches may help reduce incidence, duration and severity of acute stress disorder, post-traumatic stress disorder, and depression in survivors.
- Early interventions in the form of single on-one recitals of events and emotions evoked by a traumatic event do not consistently reduce risks of later post-traumatic stress disorder or related adjustment difficulties.
- There is no evidence that eye movement desensitization and reprocessing (EMDR) as a early mental health intervention, following mass violence and disasters, is a treatment of choice over other approaches.
- Early interventions should be delivered as needed in a manner acceptable to survivors and in keeping with best available practice.
- Effective early intervention following mass violence can be facilitated by careful screening and needs assessment for individuals, groups and populations.
- Follow-up should be offered to individuals and groups at high risk of developing adjustment difficulties following exposure to mass violence, including those who: have acute stress disorder or other clinically significant symptoms stemming from the trauma; are bereaved; have a pre-existing psychiatric disorder; require medical or surgical attention; whose exposure to the incident is particularly intense and of long duration.
- Many trauma survivors experience some symptoms in the immediate aftermath of a traumatic event. These symptoms are not a necessarily cause for long term follow-up, since most eventually remit. In general, survivors who manifest no symptoms for approximately two months following exposure to mass violence do not require routine follow-up. Of they request long-term follow-up, however, it should be provided.
- Certain interventions –mass education via media outlets, psychological triage, leadership consultations, and interventions that rely on detailed recall of traumatic experiences- have a high potential for unintended harm. The leadership should select professionals who have the high degree of training, expertise, accountability, and responsibility required to provide these interventions.
- The scientific community must develop a national strategy to examine the relative effectiveness of early interventions following mass violence.
- Early intervention policies should be based on empirically defensible and evidence-based practices.
- The use of ineffective or unsafe techniques should be discouraged.

Box 2: Early interventions: what works, what is effective?

NICE recommendations (2005)

Watchful waiting

- Consider watchful waiting when symptoms are mild and have been present for less than 4 weeks after the trauma.
- Arrange a follow-up contact within 1 month.

Immediate psychological interventions for all

- Be aware of the psychological impact of traumatic events in the immediate post-incident care of survivors and offer practical, social and emotional support.
- For individuals who have experienced a traumatic event, do not routinely offer brief, single-session interventions (debriefing) that focus on the traumatic incident to that individual alone.

Interventions where symptoms are present within 3 months of a trauma

- Offer trauma-focused cognitive behavioural treatment (CBT) (usually on an individual outpatient basis) to people:
  - with severe post-traumatic symptoms or with severe PTSD within 1 month after the event
  - who present with PTSD within 3 months of the event.
- Consider offering 8-12 sessions of trauma focused CBT (or fewer sessions –about 5- if the treatment starts in the first month after the event). When the trauma is discussed, longer treatment sessions (90 minutes) are usually necessary.
- Ensure that psychological treatment is regular and continuous (usually at least once a week) and is delivered by the same person.
- Consider the following drug treatment for sleep disturbance:
  - Hypnotic medication for short term use
  - A suitable antidepressant for longer-term use, introduced at an early stage to reduce later risk of dependence.
- Do not routinely offer non-trauma-focused interventions (such as relaxation or non-directive therapy that do not address traumatic memories.

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Shell shock

Bonding with colleagues