

CISM: Possible Liability for EMS Services?

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Critical Incident Stress Management (CISM) has been used in emergency services organizations around the world for more than a decade. First described in 1983 by Jeffrey T. Mitchell, PhD, CISM is a comprehensive, multi-component crisis intervention system. The core element of CISM is Critical Incident Stress Debriefing (CISD), a specific model of psychological debriefing that encourages emergency personnel to discuss their feelings with peers and mental health professionals.

Like many other EMS practices, CISM was launched with a paucity of supporting scientific research. Since that time, however, numerous studies have tried to determine if CISM is as effective as Mitchell and his colleagues have suggested. The answers have been controversial, with few researchers able to prove the efficacy of CISM. Even more worrisome are studies that have shown with statistical significance that CISD may actually be harmful.

In light of the uncertainty surrounding the effectiveness and potential danger of CISM, should emergency services leaders continue this controversial practice? In systems that offer CISM, what precautions should be taken to ensure that we are not doing more harm than good? Finally, what organizational risks are we assuming by subjecting employees to a potentially harmful psychological process?

A BRIEF HISTORY OF CISM

The original goal of CISD was to bring psychological closure to a critical incident or traumatic event. With the growth of CISM, and psychological debriefing (PD) in general, the goals have expanded to include:

- Preventing disorders that may result from traumatic stress, particularly post-traumatic stress disorder (PTSD);
- Screening emergency personnel to identify those who should be referred for further treatment;
- Normalizing reactions to stressful events; and
- Improving peer group support and cohesion.

The hypothesis behind CISM is that retelling details of the critical incident and experiencing a resulting emotional release helps an affected person better understand and accept the thoughts, feelings, memories and behaviors associated with the event. This process, in turn, promotes more effective resolution of the event and prevents subsequent psychiatric morbidity. The Mitchell CISD model is a seven-phased, structured group discussion facilitated by mental health professionals and peer support personnel that occurs one to 14 days after a critical event.

LITERATURE REVIEW

The most recent scientific look at CISD and PD was done by Suzanna Rose, Jonathan Bisson and Simon Wessley of England's Berkshire Health-care NHS Trust. In their research, published in the highly respected evidence-based medicine journal *Cochrane Review*, Rose and colleagues conducted a meta-analysis of 11 CISD and PD studies and found that single debriefing sessions did not reduce psychological distress nor did they prevent PTSD. They further found that there was a significantly increased risk of PTSD in those who received debriefing. Their conclusion? There is no current evidence that PD is a useful treatment for PTSD after traumatic incidents and, because of the potential for harm, compulsory debriefings should cease.

In a similar meta-analysis of psychological debriefing, Danish researchers evaluated 25 studies concerning the effectiveness of PD. They also determined that no preventive effects could be found, even though people are generally satisfied with PD. A more detailed look at the literature finds many individual studies that come to similar conclusions. For example, a study of 106 consecutive traffic accident victims in Oxford, England found that PD did not result in a significant reduction in post-traumatic or other psychiatric symptoms. In fact, the intervention group of 54 people had worse outcomes on two symptom scales. Researchers studied this same

group of patients three years later and were able to replicate their earlier findings, noting that the debriefed group remained symptomatic while the control group recovered. Their conclusion? Debriefing had no benefit and may have made patients worse.

Similar results were found in a study at the University of Wales in which researchers studied 133 adult burn victims. Study participants were randomly assigned to a PD group or a control group who received no intervention, and were interviewed at three and 13 months following their injuries. Twenty-six percent of the treatment group had PTSD at the 13-month follow-up compared to nine percent in the control group.

Researchers at the University of London studied 157 victims of violent crime who were randomly assigned to one of three groups. One group received education only, another group received PD (based loosely on Mitchell's protocol) and education, while the last group received an assessment only. At six and 11 months post-event, they found no evidence to support the efficacy of brief one-session interventions for preventing PTSD. Finally, Norwegian researchers studied 115 firefighters involved in a major 12-story hotel fire in which 14 hotel guests died. Researchers found no significant difference between the firefighters who were formally debriefed and the group who simply talked with their colleagues.

Mitchell and his partner in the International Critical Incident Stress Foundation, Inc., George Everly, PhD, have been confronted with these study results, but have repeatedly discounted them for various reasons, most commonly because debriefers did not adhere precisely to Mitchell's CISD model. Other criticisms by Mitchell and Everly include a lack of uniformity in the type of debriefing provided and the timing of the intervention. In their defense, Mitchell and Everly point to published articles in trade magazines, non-refereed journals, obscure mental health journals, and self

published books and research, the most notable of which is the *International Journal of Emergency Mental Health*, edited by Everly, and published by Chevron Publishing, an arm of the International Critical Incident Stress Foundation. But these works have been criticized by researchers from the Uniformed Services University of the Health Sciences, who found meta-analyses by Everly and colleagues were not "representative outcome studies."

IMPLICATIONS FOR EMERGENCY SERVICES

Because a critical review of the best available literature shows that CISD is ineffective – perhaps even harmful—some organizations have stopped advocating psychological debriefing following a critical incident. The British Health Service, for example, lists routine debriefing as a contraindicated procedure in its *Evidence Based Clinical Practice Guideline* and concludes that, "Review of the best-designed studies suggests that routine 'debriefing' (a single session intervention soon after the traumatic event) is not helpful in preventing later post-traumatic disorders." The Australasian Critical Incident Stress Association, in its guidelines for CISM practice, states that, "...experience and systematic investigations have revealed a marked discrepancy between outcome once presumed to be achievable (Mitchell, 1983; Mitchell and Everly, 1995) and those that can be reliably delivered (Rose and Bisson, 1998)."

In addition to being possibly ineffective and potentially harmful to employees, forced debriefing holds the potential for legal complications related to the issue of informed consent. Although CISM was originally developed to help normal people with normal feelings and emotions deal with a catastrophic event, it later evolved to prevention of PTSD and other psychiatric symptoms. With that change, it functionally became a form of mental health care, and with that came the requirement that personnel who undergo CISM/PD must provide informed consent.

According to the American Counseling Association, "Individuals have the right to be informed about the options available for

treatment interventions and the effectiveness of the recommended treatment." Likewise, calling into question the notion of peer counseling, the ACA says that, "Individuals have the right to receive full information from the potential treating professional about that professional's knowledge, skills, preparation, experience and credentials." Informed consent must include a summary of the current state of the science supporting the procedure. Likewise, the consent must notify the personnel that there have been negative effects associated with the intervention. Only following explicit informed consent should CISD/PD be initiated.

Even with a signed informed consent, forced debriefing may pose a civil liability if an employee who perceives that he or she is harmed by the forced debriefing demonstrates that the scientific literature has shown that CISD may cause iatrogenic harm. The lack of quality studies in respected peer-review journals supporting the efficacy and safety of CISM would further inhibit defense of the case.

There are some other legal potentialities that discourage the use of CISM. The first is that exposing peers to additional trauma could cause them to exhibit psychological symptoms. Mitchell, himself, acknowledged the impact of debriefing on the debriefers in his book *Emergency Services Stress*. "[D]ebriefing is a powerful experience for the debriefing team as well," Mitchell wrote. "They need to talk about how the debriefing affected them. They need to get their emotions out in the open before they go home and feel depressed. Debriefers need support as well, and they get it from one another." Managers must ask if we want to place our employees in harm's way by allowing them to serve as peer counselors during debriefings, when the process may cause them to vicariously relive the traumatic event and perhaps experience symptoms similar to the primary victims.

There also is the problem of confidentiality of mental health interventions, which is among the most sacred in health care. Placing non-mental health personnel in a pseudo-mental-health role in which they encourage participants to share their feelings and emotions with others may violate this confidentiality.

THE FUTURE OF CISM

There is a role for mental health personnel in emergency services. But rather than facilitate formalized debriefings, mental health professionals might be better used to screen affected personnel for signs and symptoms that may indicate later psychiatric morbidity. This task can be performed only by competent mental health personnel experienced in the art and science of psychology or psychiatry. Following their assessment, personnel deemed at risk may be referred for additional therapy.

It is important to remember that PTSD, the most severe psychiatric disorder associated with a traumatic event, is an abnormal response to the event and only occurs in a small number of people. Providing an intervention that could possibly increase the chances of an employee developing PTSD is highly unethical.

Finally, the delicate nature of critical incidents calls for additional prospective, randomized, controlled studies looking precisely at Mitchell's model as well as other forms of PD used in emergency and disaster services. Studies also should evaluate whether occupational stress is actually any higher in emergency service workers compared to the population at large.

Until that research is completed, we must rely on the current best-available literature published in first-tier medical journals, which has demonstrated that CISD/PD does not make any difference and may in fact be harmful. The types of studies cited here, for the most part, have been prospective randomized controlled trials that show no benefit or a negative benefit from CISD/PD. Prospective randomized controlled studies represent the highest level of scientific evidence validity. That is, the more valid the study, the closer it is to the truth. Using the same criteria that the American Heart Association used in their Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiac Care, CISM/PD would be given a Class III (unacceptable, no documented benefit, may be harmful) rating.

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