Attending to debriefing as post-incident support of care staff in intellectual disability challenging behaviour services: An exploratory study

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Abstract

Background: The psychological welfare of the workforce who support people with intellectual disabilities who present challenging behaviour is key in providing effective positive behavioural support. This workforce has consistently been identified as being vulnerable to experiencing poor psychological wellbeing. Debriefing after incidents is consistently recommended as good practice, despite the absence of clear guidance about the nature of the debrief and an adequate evidence base.

Method and materials: A case study is presented in relation to a group debrief in which the critical incident stress management (CISM) model was carried out for six staff involved in a serious incident. Staff were assessed prior to the debrief and in a two-month follow up using the impact of events scale – revised (IES-R) (Weiss and Marmar, 1997).

Results: Worryingly high IES-R scores for four of the staff were found prior to the debrief. At two-month follow up all staff scores had reduced to levels below the cut-off for clinical concern.

Conclusions: Implications from the analysis of this case study are discussed in relation to general support and, specifically, post incident support offered to staff in intellectual disability services.

Keywords: Challenging behaviour, intellectual disability, debrief, critical incident stress management

Introduction

The impact on the psychological wellbeing of staff who are exposed to challenging behaviour when supporting people with intellectual disabilities is complex, and only partially understood. Although there is evidence that some direct support staff report working with people who present challenging behaviour can be stressful (eg Hastings, 2002), this is by no means a straightforward linear relationship, with some research suggesting that characteristics of the work environment, rather than the behaviour of the individuals they support, have more influence on staff stress (Skirrow and Hatton, 2007; Thomas and Rose, 2010). Not surprisingly, there is also evidence that the nature and type of incident will affect the emotional response of staff, with more negative responses reported to violent incidents that may also involve restraint (Hastings, 2005).

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Employers have legal and moral responsibilities to maintain the wellbeing of their workforce, with the obvious payoff of reduction in sickness rates and staff turnover. Furthermore, the link between any emotional impact of the challenging behaviour and the staff member's ability to provide appropriate positive behavioural support (PBS) has been persuasively argued, in particular the potential for these emotional states to precipitate and maintain staff behaviours that may in turn reinforce the challenging behaviour of the person with an intellectual disability (Hastings, 2005). Put in behavioural analytic terms, challenging behaviours can be aversive for staff, and if their responses make the challenging behaviour stop, these responses will be negatively reinforced by the termination of the behaviour, whilst the challenging behaviour of the individual will be reinforced and maintained over time. Adopting PBS strategies is likely, in the initial periods, to take more effort and require more 'resource' from direct support workers. Staff who have reasonable levels of wellbeing are more likely to have the necessary resources to be able to make these efforts and follow PBS plans (Hastings, 2005; Hatton and Emerson, 1993; Razza, 1993).

Various studies attempted to identify the organisational factors that might contribute to the ongoing maintenance of emotional wellbeing of staff working in intellectual disability challenging behaviour services. For example, role ambiguity, role conflict and the adequacy of managerial support were all demonstrated to have a relationship with low feelings of self-efficacy (Hastings, 2002). Vassos, Nankervis, Skerry and Lante (2013) produced similar findings and suggested addressing such issues by improved job descriptions, on-the-job feedback and specialist support of staff. Training in PBS has been demonstrated to have positive impacts on staff attributions with staff more likely to engage in proactive strategies, less likely to engage in unhelpful behaviour, and reporting higher levels of optimism in supporting a service user with challenging behaviour (Lowe et al, 2007; McGill, Bradshaw and Hughes, 2007; Wills, Shephard and Baker, 2013). In addition, there is a limited evidence base of the effectiveness of acceptance and mindfulness based interventions on psychological distress and wellbeing of support staff. There is also some more limited evidence of a reduction in service user challenging behaviour and the use of restrictive practices (McConachie, McKenzie, Morris and Walley, 2014; Noone and Hastings, 2011; Singh et al, 2006; Smith and Gore, 2012).

Arguably, the point at which staff would experience the greatest risk to their emotional wellbeing is during and immediately following an incident of challenging behaviour. Debriefing following incidents of challenging behaviour has received little critical scrutiny, but certainly in the UK, appears to be accepted as good practice by default. For example, in *Positive and Proactive Care* (Department of Health, 2014), guidance on reducing the need for restrictive practices, it is stated that debriefing is essential, highlighting its importance for learning from the event and supporting the staff emotionally. On a similar note, *Positive Practice: Reducing Restrictive Practices in Social Care* (guidance for Wales) states that when restrictive practices are used they should always include a debrief of all those involved, and this should occur immediately or shortly after an event to offer support and reassurance. The guidance goes on to specify that this should be an opportunity to identify any learning or good practice (Care Council for Wales, 2016).

Similar guidance is also to be found in mental health services in the *Code of Practice for the Mental Health Act 1983* (DoH 2015), which states that:

> *26.167 Following any episode of acute behavioural disturbance that has led to the use of a restrictive intervention, a post-incident review or debrief should be undertaken so that involved parties, including patients, have appropriate support and there is opportunity for organisational learning. It is important that patients are helped to understand what has happened and why. Patients with limited verbal communication skills may need support to participate in the post incident review or de-briefing. (p310)*

The recommendation of a requirement to debrief is certainly not uncommon, with numerous references to debriefing as a response to challenging behaviour incidents in practice guidance (eg BILD, 2014; Paley-Wakefield, 2013). When the purpose of the procedure is elucidated, more often than not the imperative for organisational learning is typically coupled, or even confused with, emotional support of staff. It is not surprising that good practice guidance would emphasise the importance of learning from incidents which have resulted in the use of restrictive interventions. What is somewhat surprising is linking the emotional support of those involved with the process of organisational learning as if the two were synonymous, which

they clearly are not. This could be easily caricatured as attempting to emotionally support a member of staff who has just been involved in an incident of challenging behaviour by asking them to tell you what they did wrong or getting them to elucidate their role in the causation of the event. This would clearly be nonsensical and counterproductive.

The uncritical acceptance of the prescription of debriefing is also curious given that neither the National Institute for Health and Clinical Excellence guidance (NICE, 2005) nor the Cochrane review (Rose, Bisson, Churchill and Wessely, 2006) for post-traumatic stress in the UK recommend debriefing. These recommendations are specifically in relation to individual debriefing to treat trauma, and state that single session interventions that focus on the incident should not be routine practice. Nonetheless, this has resulted in many organisations outside of the field of intellectual disability not providing debriefing to employees who face trauma in their routine work. Hawker, Durkin and Hawker (2011) recently challenged the NICE guidance, however, in particular citing the quality of the papers selected and the extent to which they adhered to what would be considered good practice in the field, including session length, timing and inadequate training of the people carrying out the debriefs.

Critical incident stress management (CISM) is a comprehensive peer support programme which was originally developed for emergency service personnel following exposure to critical incidents (Mitchell, 1983). Critical incident stress debrief (CISD) is part of this comprehensive programme. This is a group intervention and includes the detailed disclosure of facts, thoughts and emotional reactions and sensory material linked to the event or incident, coping factors involving education and traumatic stress, normalisation of responses, anticipatory trouble shooting and planning for the future, and facilitated group support (Lewis, 2003). The CISM model has been adapted and applied to a variety of organisational contexts in order to, amongst other things, improve staff retention and morale including nursing, social work and allied health professions (Pack, 2013), although only one old study could be found that dealt specifically with CISM in intellectual disability services (Matthews, 1998). The evidence base in regard to CISM is at best patchy, and certainly contradictory. Pack (2013) cites various problems including lack of clarity in regard to definitions and outcomes, ranging from morale boosting through to prevention of post-traumatic stress disorders. In addition, there is confusion in relation to the distinction between CISM and CISD, with some conceptualising CISM as a single one-off intervention and others seeing CISD equivalent to counselling, without reference to its wider systems elements.

There is clearly a need for greater clarity in relation to best practice in the manner in which staff are generally supported and specifically following incidents of behavioural disturbance, both in relation to the requirements for organisational learning and the post-incident emotional support of those involved. This paper will attempt primarily to contribute to the latter by presenting a case study of the impact of a serious incident that occurred within a specialist service for people with autism and learning disabilities. It is acknowledged that both emotional support and organisational learning are equally important, but in the absence of evidence that they can be dealt with as if they are the same, they will be treated here as separate processes with different goals.

Case study

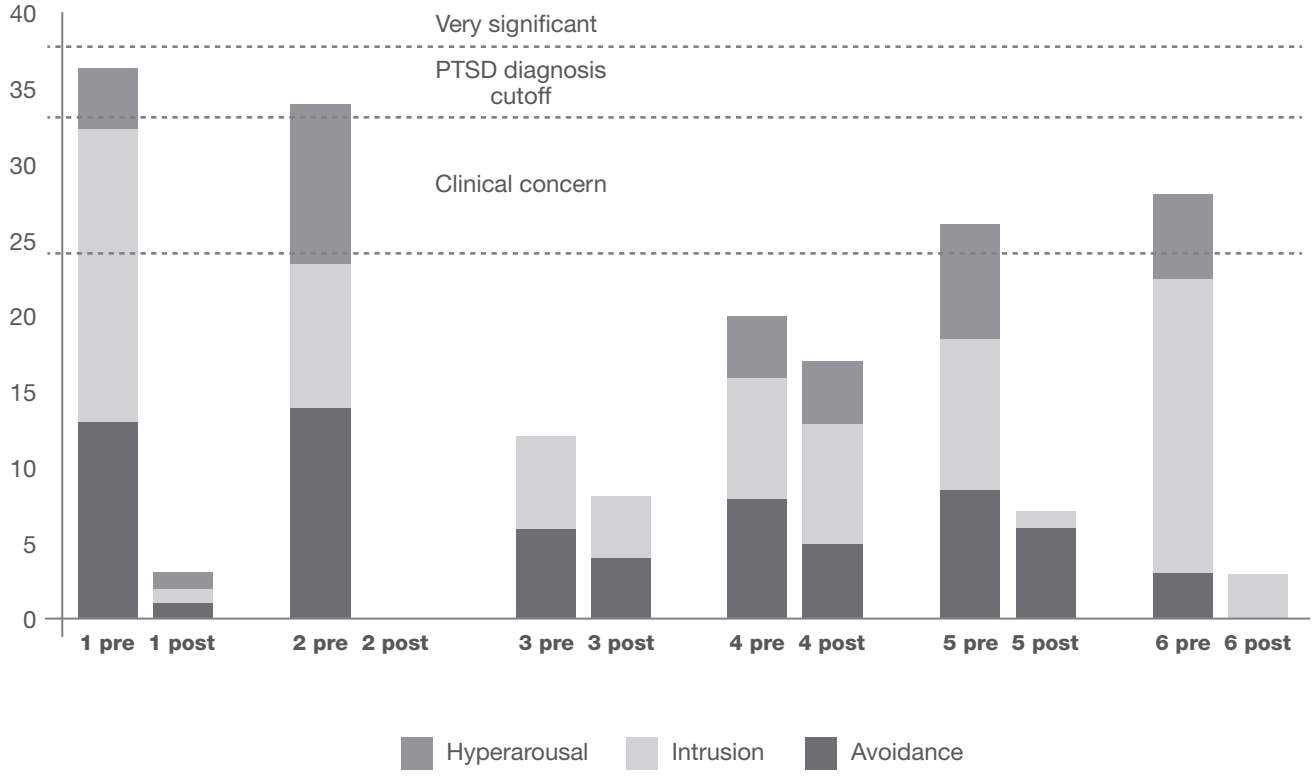
Method

A serious incident involving challenging behaviour had occurred in a specialist autism learning disability service. The incident involved a 21-year-old man with a diagnosis of learning disability and autism. The incident involved injury to another service user, and staff members, and culminated in the young man throwing himself through a window in a partition door resulting in serious laceration of his abdomen, injuries that required treatment at the accident and emergency department of the local district general hospital. The residential staff from the service supporting the man in the hospital were initially informed that he would not be returning to the specialist residential unit. This plan was changed whilst they were in the general hospital and, eventually, they had to support him back to the specialist unit where the incident had occurred. During the course of their time in the general hospital they experienced significant difficulties in contacting out of hours support from their own organisational management and the specialist community intellectual disability support team. Once returned to the unit the young man stayed for a further 48 hours before he was admitted to an assessment and treatment unit, with the staff experiencing considerable difficulty in maintaining the safety of all concerned.

Six staff (four women and two men, direct support workers and middle managers) from the specialist residential unit were involved in the incident and all reported that they found the incident difficult and stressful. A CISD was offered by the author who, at that time was a clinical psychologist working at the local NHS community learning disability service and had been trained in CISD. This session was held at the service and was over two hours duration. It followed the prescribed CISD protocol, consisting of: the detailed disclosure of facts by the participants; elicitation of thoughts and emotional reactions and sensory material linked to the incident; elucidating coping strategies involving education on traumatic stress with the goal of normalisation of participants' responses; and anticipatory trouble-shooting and planning for the future (Lewis, 2003). Attendance was voluntary; the session was scheduled for three weeks after the incident, and took place in the specialist residential service. All six staff involved attended and agreed to complete the impact of events scale – revised (IES-R) (Weiss and Marmar, 1997). This is a questionnaire designed to measure subjective responses to a specific traumatic event, especially in the response sets of intrusion (intrusive thoughts, nightmares, intrusive feelings and imagery, dissociative-like re-experiencing), avoidance (numbing of responsiveness, avoidance of feelings, situations, and ideas), and hyperarousal (anger, irritability, hypervigilance, difficulty concentrating, heightened startle), as well as a total subjective stress IES-R score. The measure has 8 items related to intrusion, 8 to avoidance and a further 6 related to hyperarousal, corresponding directly to 14 of the 17 DSM-IV symptoms of PTSD. Interpretation guidelines suggest that an overall total of 33 out of 88 or above provides good diagnostic accuracy for PTSD. Scores over 24 are of clinical concern and likely to mean full or partial PTSD. Participants were required to complete this specifically in relation to the incident previously described. This was administered prior to the CISD and at two-month follow-up. In order to preserve anonymity, no additional identifying information was collected, given such a small number of participants.

Figure 1: The scores of each staff member on the IES-R immediately before and six weeks after the debriefing

Results



Results

Prior to the debriefing two staff members were scoring in the range indicative of PTSD, a further two were in the clinical concern range and the remaining two were below this cut off. At follow-up, no staff members had scores in or above the clinical concern cut off. The mean scores had decreased by 58% (range 15–100%), with the subscale of hyperarousal showing the biggest percentage decrease of 84%. Of note was that the two staff members with the lowest scores prior to the debrief had the lowest percentage decrease (15% and 66%). They also had the highest scores at follow up.

Discussion

This is a case study based upon a quasi-experimental design and, as such, no inference regarding causation can be drawn. However, a number of important issues and questions are raised. The high scores on the IES-R of the staff involved in this particular incident give cause for concern if they are at all representative of typical responses in staff to such incidents. Whist the incident that they had to deal with was clearly impactful, it would by no means be considered to be rare. The literature that has examined the emotional responses of staff who are managing challenging behaviour presented by people with intellectual disabilities has rarely done so through a trauma-informed lens and will typically use concepts such as burnout, stress, emotional exhaustion, etc. Whilst these concepts are clearly related, and often trauma is conceptualised as a more extreme form of stress, they are also arguably subjectively different, and it remains to be seen what the implications might be of using a trauma-informed framework to look at staff experience of involvement in incidents of challenging behaviour.

Whilst it is impossible to disentangle the role that CISD played in the significant reduction in the IES-R scores, they did undoubtedly reduce. Four of the staff members had reduction in scores that took them out of the PTSD and clinical concern range into the range below cutoff. The design makes it impossible to state categorically the cause for the reduction. A plausible explanation might be passage of time, given the evidence that whilst symptoms may manifest in the short term, prevalence in many instances will diminish over time (Bisson, 2007). It may also have been the case that other sources of support were effective, or the fact that the individual was no longer in the service resulted in the reduction of IES-R scores. Notwithstanding, this at least should encourage further investigation of the efficacy of CISD or similar models of post-incident support. Two members of staff who were already below the cut off only had modest reductions in scores. Whilst no subjective report is available from these staff, it raises the obvious possibility that they did not benefit from the debrief. Nonetheless, their scores did reduce to some extent, suggesting at least an absence of evidence that the debrief was harmful. The implication is that debriefing should perhaps not be the only option available.

What is clear is that the evidence base to guide good practice is currently extremely thin and that a considered examination as to what works is vital. This should not be restricted to post-incident support, but should also be a strength based approach, looking at evidence based strategies for building staff emotional resilience. This would be in keeping with the system-wide focus of CISM and should consider organisational culture, and such factors as practice leadership, supervision, training, and so on. Such an approach would have direct parallels with the way in which PBS focuses on both proactive and reactive strategies in relation to challenging behaviour. A similar multi-faceted approach to staff emotional welfare is indicated.

Given the widespread recommendations in regard to the imperative for debriefing, it might also be wise to provide interim guidance for post-incident support based on the current limited evidence base. Although the evidence base regarding the effectiveness of debriefing is contradictory, there does seem to be a case for the continuation of group debriefing following potential traumatic incidents, on the basis that there is no persuasive evidence that it will do harm.

The following points are considered to be in keeping with the current state of knowledge in this area and should be considered to be interim guidance:

- It is clear that strategies designed to provide emotional support for staff should be separated from the responsibility to provide organisational learning from the incident.
- A range of interventions should be offered on a voluntary basis. Horn, in Williams and Sommers (2002) investigated the experience of police officers involved in the Oklahoma bombings in 1998 and suggested a number of options including residential workshops, one-to-one sessions, chaplaincy, and EMDR therapy. The context here of course is very different to intellectual disability services and the options are likely to be different, but the lessons regarding a voluntary range of options would at this point appear apt.

- Adequate debriefing needs to be of sufficient duration and not too soon after the event, and carried out by trained experienced debriefers (Hawker et al, 2011).
- Training of debriefers needs to fit the context, with the implications of a debriefing model constructed specifically for staff managing challenging behaviour presented by people with intellectual disabilities (Hawker et al, 2011).
- Debriefing should be carried out by clinicians who are familiar with the context of the work carrying out the debriefs (Horn, 2002).
- Prior history of trauma may either sensitize or immunise staff to subsequent trauma, depending or not whether they had worked through earlier trauma (Horn, 2002). Getting staff to reflect on their own personal trauma history as a specific psychoeducational strategy, may well be helpful in facilitating each individual to select the most effective type of support.

Clearly there is an urgent need for further research in this area. There is a moral, ethical and legal requirement in most jurisdictions to attend to the wellbeing of paid staff, notwithstanding the direct impact that this has on the ability of these staff to provide supportive interpersonal environments for people with intellectual disabilities. There is also a parallel work stream, outside of the remit of this paper, to review the elements of a supportive organisational environment that proactively promotes staff emotional resilience. This would be particularly important in service environments with high rates of challenging behaviour. In addition, the support available to families and people with intellectual disabilities, either directly or indirectly, also requires careful attention.

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