An Evaluation of the Process Impact and Outcome of a Debriefing Programme

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Sharon Leadbetter

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ABSTRACT

Most people will be exposed to some form of traumatic incident during their lifetime. These traumatic incidents cam be devastating for those involved and could lead to long-term psychological problems. The difficulty in dealing with these traumatic incidents, and preventing occupational stress, (especially in high-risk occupations) led to the development of psychological debriefing.

The evaluative literature on debriefing has produced mixed findings on its effectiveness. To date most of the literature finds debriefing to have minimal or no effect on minimising the psychological morbidity associated with critical incidents, such as Post-Traumatic Stress Disorder (PTSD). However, there are many methodological and implementation issues in the evaluative research into debriefing, which need to be addressed.

The present study was intended to collect baseline data on the effectiveness of the debriefing programme at a mental health unit. The 18 participants were given a questionnaire that contained several measures examining, attitudes, knowledge and experience of debriefing, as well as measures assessing psychological and physical health, and job satisfaction.

Independent samples t-tests revealed a strong significant relationship between knowledge and debriefing status. The present study revealed the importance of process and impact in the design and implementation of a debriefing programme. Future research should examine the process and impact issues raised in the present study using a larger sample size.

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INTRODUCTION

Psychological Trauma

Psychological trauma is defined as "a person's response to a sudden, unexpected, potentially life-threatening event, over which he or she has no control, regardless of how hard the person tries. The American Psychological Association (APA, 1994) defines a traumatic event as one "that must involve intense fear, helplessness or horror" (p. 424). It may involve "actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm or threat of death or injury experienced by a family member or other close associate" (APA, 1994, p. 424). This definition now recognises the possibility of trauma being experienced by someone not involved in a traumatic event (vicarious traumatisation).

There seems to be a common tendency to underestimate the impact of trauma. One reason may be that some traumatic events are rare. Thus it can be difficult for people who experience traumatic events to understand what is happening to them (Robinson, 1995). It can also be hard for family, friends or colleagues to appreciate the extent of the impact the traumatic event has had on a person, and the psychological distress it can cause.

Evidence shows that most people will experience a traumatic event at some point during their lives, often while they are still quite young (Breslau, Davis, Andreski, & Peterson, 1991). The frequent occurrence of traumatic events is one reason for finding preventive interventions to put in place. There will always be traumatic events occurring and insufficient numbers of mental health workers to help (Norris & Thompson, 1995). Often traumatic events do not arouse much widespread interest especially if only one or two people are involved, such as with car accidents or assaults. These experiences can be very isolating and mental health workers may not show the same concern in providing preventative interventions for them. This is one of the reasons why individual

traumatic events present a greater public health challenge than disasters, which occur infrequently (Raphael, Wilson, Meldrum, & McFarlane, 1996).

Over the last two decades, there has been a growing awareness of the huge impact traumatic events can have on the health of employees. Workers' mental health can be severely compromised by traumatic events occurring in the workplace. This realisation has led to some organisations providing employees with support and the recognition that their mental health is just as important as their physical health (Mitchell, M., 1999). There are also many potential secondary victims in work-related traumatic events, such as fellow workers and the organisations themselves, and the emergency workers, and debriefers who helped during and after the event (Nurmi & Williams, 1997). This demonstrates the far-reaching effects of traumatic events, and provides more reasons for organisations to put trauma education and support programmes in place.

The emotional response to a traumatic event consists of many interacting factors, such as a possible post traumatic stress or grief reaction, individual variables, which include personality styles, coping skills and support systems; and trauma specific elements that need to be looked at, according to Williams (1993). Bell (1995) believes all stress reactions fall into four clusters; physiological (diarrhoea, sleep disturbance, change in appetite), behavioural (hypervigilance, withdrawal, lack of social interaction), cognitive (poor concentration, confusion, flashbacks), and emotional (depression, fear, anxiety). People can experience these stress reactions weeks after the traumatic event, even if they originally felt fine. If these symptoms become unmanageable and interfere with a person's everyday life, the chances of developing Post-Traumatic Stress Disorder (PTSD) are greatly increased (Bell, 1995).

Post-Traumatic Stress Disorder

Traumatic stress reactions can be viewed as being on a continuum. At one end of the continuum is the idea that all traumatic events do not have to be viewed in a negative light. In fact, some people who have been involved in a traumatic event have said that they gained a lot from the experience. This can involve feeling a new appreciation for life, the chance to help others in need and feel useful, or it was a time that people learnt

something beneficial about themselves. Unfortunately though, most peoples' experience of a traumatic event is not so pleasant. It is often a distressing time for them and their loved ones. This is the other end of the trauma continuum.

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) recognises two psychiatric disorders that could develop as the result of exposure to a traumatic stressor: Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder. According to the DSM-IV (APA, 1994) the key features of PTSD are,

a) Exposure to a traumatic event of extreme intensity
b) Recurrent experiencing of the traumatic event, such as flashbacks or dreams
c) Avoidance of factors associated with the trauma and a numbing of general responsiveness
d) Persistent symptoms of arousal, stress or anxiety
e) A duration of symptom clusters b, c, d for more than one month
f) The symptoms must cause significant distress or impairment

The APA (1994) states that PTSD can be experienced by anyone, and its symptoms usually begin within the first three months after the traumatic event (but delayed onset is also not uncommon). The APA also says that around half the cases achieve complete recovery from PTSD within three months. Symptoms can also last longer than a year after the traumatic event for a number of people, which seems to indicate that PTSD can become a chronic illness.

However, an individual's symptoms usually meet the criteria for Acute Stress Disorder in the days after a traumatic event. Acute Stress Disorder must occur within 30 days of the traumatic event, and resolve within that same time frame, as it involves the same types of stressors and symptoms as PTSD (APA, 1994).

Most people, it should be noted, are fairly resilient, and in time are able to gather the resources necessary to cope with such traumatic events by using their inner strength, and with the help and support of their families and friends, get on with their life. However, there are others who are either unable to cope with the traumatic event or are exhausted from the effort of trying to sustain themselves (Hutt Valley Health, 1999). Parkinson (1993) emphasises that people who were in a traumatic event can be in denial

about the affect the event has had on them, some will believe they are fine, when in fact, the effects of their trauma might become chronic. On the other hand, most people will usually cope with their experience over time, but all will be affected in some way.

Post-traumatic stress is a normal reaction to an abnormal event. It is the emotional and behavioural aftermath of a distressing event, and serves to remind people that a traumatic event has occurred. But most people can only deal with so much at a time before they begin to feel overwhelmed and their ability to function effectively becomes impaired. PTSD is a more problematic, longer-term response to either a traumatic event, or to the person's natural healing processes having become delayed (Mayhew, 1997). People who develop PTSD become fixated on the traumatic event. They relive it in thoughts, feelings, actions or images, and this is what determines if someone has PTSD, not the traumatic event itself (Van der Kolk, McFarlane, & Van der Hart, 1996).

Bessel A. Van der Kolk has done a great deal of work in this area. His summarised findings on the experience of PTSD, from Van der Kolk et al. (1996) will be elaborated on here. Once people become controlled by intrusions of the traumatic event, they will go to great lengths to avoid experiencing them. Avoidance can occur in many ways; keeping away from places, people or emotions that remind them of the traumatic event, or drinking alcohol to forget the traumatic event, thus numbing their senses to it. Peoples' experiences of not being able to control the intrusions, and constantly living in a hyperaroused state can devastate them, and affect their whole perception of life. Sufferers of PTSD also tend to find upsetting thoughts and strong emotions very overpowering.

Van der Kolk et al. (1996) goes on to say that intrusions of the traumatic event are experienced as; flashbacks, affective states, somatic sensations and nightmares. Traumatised people spend their energies on avoiding these distressing internal sensations, conscious of the fact they are not coping. Therefore they are not able to focus on the environment around them. People with PTSD tend to deal with their environment through a type of emotional shut down, but their body is still conditioned to react to reminders of the traumatic event as an emergency so they have increased autonomic arousal. This physiological hyperarousal also interferes with the person's

ability to concentrate and to learn from experience, and sometimes even remembering ordinary, everyday events.

Deahl, Gillham, Thomas, Searle, & Srinivasan (1994) note, it is acknowledged that people with PTSD avoid getting help for this disorder, as to them, this would remind them of the traumatic event. This avoidance to seek help is further heightened in those professions where help seeking is perceived as a weakness, such as in the police force, fire service and nursing. PTSD is associated with; changes in behaviour, difficulties at work, and relationship problems say Deahl et al. The APA (1994) states that people with PTSD may describe feelings of guilt about surviving, or about things they had to do to survive. Workers in high-risk occupations should be assessed for symptoms of PTSD. This is especially important in occupations where help seeking or talking about feelings is not encouraged (Deahl, et al.).

PTSD is the most widely recognised consequence of trauma, but it is far from being the only one. In fact, some authors have found many victims of traumatic events go on to develop other psychological disorders, co-morbid with PTSD, such as depression and anxiety (McFarlane, 1995a), and alcohol and drug abuse (Davidson, Foa, Blank, Brett, Fairbank, Green, Herman, Keane, Kilpatrick, March, McNally, Pitman, Resnick, & Rothbaun, 1996). These authors also found a 62% to 98% rate of co-morbid psychiatric illness in people with chronic PTSD, as chronic PTSD is a very rare condition on its own. Thus, the emotional and physical symptoms of traumatic events do not single handedly lead to PTSD, but they may in fact precipitate any one of a number of other mental disorders. These disorders can have distressing effects on victims' lives and markedly interfere with their functioning at personal, social and occupational levels.

The American Psychological Association (1994) found community based studies showed 1% to 14% lifetime prevalence for PTSD. Studies of at-risk individuals, such as war veterans or victims of crime yielded prevalence rates ranging from 3% to 58%. In association with this, is the epidemiology review of PTSD studies by Davidson et al. (1996), which found community samples that were not at risk for PTSD, had a lifetime prevalence of PTSD between 1% and 2.6%, whilst 6.6% to 15% exhibited sub threshold symptoms of PTSD. This indicates that the risk of developing PTSD, for those deemed not at-risk, is still high.

There is little information about the long-term effects of PTSD. However, the results of long-term studies of populations affected by traumatic events that have been done, indicate a large number of survivors suffer from the after effects of the traumatic events for long periods of time (Shalev, 1994). Fourteen years after the collapse of a dam at Buffalo Creek, Green et al. (1990, cited in Yule, 1999), found that 17% of the adult survivors still met the criteria for PTSD whilst Kilpatrick, et al. (1987, cited in Yule, 1999), found 17% of woman were still eligible to be diagnosed as having PTSD, seventeen years after being sexually assaulted. Studies of Vietnam veterans have reported that many of these former soldiers had a delayed onset of PTSD. It has also been established that even fifty years after World War Two ended, people are still recognised as being sufferers of PTSD (Yule, 1999). Kessler et al. (1995, cited in Bisson, 1997) demonstrated that even with treatment, PTSD failed to remit in over one third of cases.

Emergency workers are vulnerable to the effects of post-traumatic stress too. They are the unseen victims of disasters and traumas because they are exposed to huge traumatic events, which are extremely stressful, involve demanding work and minimal rest (Ursano, McCaughey, & Fullerton, 1994). Thus, repeated exposure to trauma can put rescue workers at increased risk of developing PTSD (Breslau et al., 1991). Everly (1995) discusses two cases that examined PTSD; one investigated the role that traumatic events played in being an occupational risk factor for metropolitan fire fighters and found a 16% prevalence rate of PTSD. The other evaluated the degree of stress within a sample of London ambulance workers, and found a 17% prevalence of severe stress.

Raphael (1980) has emphasised that the difficulties associated with the prevention of psychiatric disorder lie in several areas, such as the aetiology of the disorder, the outcomes of what is being prevented, the techniques and processes, methodological problems and ethical issues. Raphael (1980) concluded the study by stating that most of the work in this field corresponds to a need for prevention.

Mental health professionals face a range of difficulties in trying to provide an efficient response to dealing with trauma. These can include the psychological, physiological, behavioural, cognitive and emotional reactions from the people involved in the traumatic event, ascertaining the significance of any psychiatric symptoms someone

might be displaying, in relation to predicting disorder, (as symptoms be a reflection of a healthy or unhealthy response to trauma), and all the other variables not related to the current event, such as a person's coping style, previous psychiatric history or upbringing (Shalev, Schreiber, & Galai, 1993).

A great deal of the research on traumatic events has been on rescuers and survivors of major disasters, who have been subjected to prolonged periods of stress. However, post-traumatic stress reactions are being increasingly recognised in survivors of brief traumatic events, such as road accidents and violent crime. Therefore, more attention is being paid to interventions designed to reduce the risk of chronic post-traumatic stress reactions (Canterbury & Yule, 1999).

Due to its prevalence and difficulty in being treated, preventing PTSD has now become a necessity. Van der Kolk et al. (1996) believe after a traumatic event the emphasis needs to be on providing support and reassurance for people, and helping them get back into their normal routines. It also means encouraging people to talk with other victims and to look after themselves. Ursano, Grieger, and McCarroll (1996) believe the prevention of PTSD should focus on the acute and the chronic forms of the disorder, as the development of both forms seems to be quite different. It is important to differentiate which is being prevented, as each form of the disorder may require different environments to flourish, thus requiring different methods to prevent them. One type of intervention that was set up to help prevent or minimise the effects of PTSD was psychological debriefing

Debriefing

Psychological debriefing is a mental health intervention and falls under the category of secondary prevention. Its goal is to prevent or mitigate traumatic stress. It is group orientated and encourages people to talk about a traumatic event they were involved in that may have upset them. However it should be remembered that traumatic events do not always result in upsetting outcomes for those involved. Positive experiences can also be gained from traumatic events, and some people can cope remarkably well (Ursano et al., 1996). In a psychological debriefing people review their involvement in

the traumatic event, their thoughts and feelings about that event, and they are taught about common stress reactions and what to expect when they go home or return to work (Armstrong et al., 1998). It could be defined as a kind of emotional catharsis.

The idea behind secondary prevention is the early identification and treatment of problems to limit any possible distressing psychological symptomology in the future. Ursano et al. (1996) argue that intervening immediately after a traumatic event with a prevention programme can help prevent the onset of distressing psychological symptoms. Canterbury and Yule (1999) believe preventive interventions need to assess all the variables in a traumatic event, such as the circumstances surrounding the event and the people involved, and regard each traumatic event as a different experience for each individual (victim or emergency worker) involved. Any psychological interventions should complement an individual's natural coping response, and be available whenever the individual requires it (Canterbury & Yule, 1999).

Debriefings follow a variety of structures, but they usually encompass a thorough review of the traumatic event and of the participants' thoughts and feelings, talk about what participants did that was satisfying during the event, discussion about coping strategies and an application of a stress management technique. One of the strengths of debriefing, Solomon and Shalev (1995, p. 243) believe, is that "debriefing addresses all the survivors of the event and uses the group's natural resources and does not label any individual reaction as deviant or pathological". Solomon and Shalev also state that implied in the practice of debriefing are the assumptions that peers can aid in each others healing and that traumatic events are addressed more successfully in natural groups.

According to Williams and Nurmi (1997, p. 197) "the principles of debriefing are immediacy (as quickly as possible), proximity (as close to the scene as safety allows), and expectancy (for recovery and that one's reactions after the event are normal, instilled in the victim by the debriefer)". "Debriefing is thought to allow victims of psychological trauma to be able to process their experience cognitively and emotionally, with immediacy thought to enhance the effectiveness of debriefing" (Deahl, et al., 1994, p. 60).

Debriefing is intended to be a voluntary programme. Yet there are examples, such as debriefing of bank employees in both the United Kingdom and Australia (Wessely, Rose, & Bisson, 1999) and in some United Kingdom police forces (Mitchell, 1999) and in the New Zealand police force (Black, 2001) when it can be compulsory. According to Wessely et al., (1999) mandatory debriefings are provided to protect organisations from getting sued by people who develop PTSD, as it is presumed that debriefings can prevent PTSD from developing.

Debriefing is available to individuals who were directly involved or personally affected by the traumatic event. The timing of the debriefing is important; it should not be held too soon after the traumatic event, as this also allows for information about the debriefing to get out so that other people may choose to attend. Usually a debriefing is held two to four days after the traumatic event, although there are differing opinions on the best time to offer a debriefing.

Shalev (1994) summarises the history of debriefing. A type of group debriefing following combat exposure was developed during World War Two, by the chief historian for the American army, Brigadier General Samuel Lyman Atwood Marshall. Many combat units used his method during World War Two and again in the Korean and Vietnam Wars. Although focused on gathering historical data, it resulted in profound psychological changes among the soldiers debriefed, according to Marshall. Shalev believes Marshall's debriefing technique reflects many of the stages of the more recent forms of debriefing. For instance, debriefing sessions took place on the battlefield as soon as possible after the action. All survivors of the battle were present except the injured. Prior to a debriefing session, Marshall learned all about the battle and the role that was played by the combat unit to be debriefed. Also, during the debriefing military ranks were disregarded; everyone was equal.

In the early 1980s, debriefing was modified for use with emergency workers following disasters. Prior to the 1980s, there is a scarcity of literature relating to the psychological effects on staff that work with traumatised individuals (Rose, 1997) and on emergency service workers (Mitchell & Dyregrov, 1993). Raphael et al. (1996) agree many emergency workers have appreciated the opportunity of an emotional release or just the chance to talk, after a traumatic event. Therefore, before the current models of

debriefing became fashionable and formalised, informal social gatherings may have partly fulfilled some of the same functions.

Debriefing is not to be confused with defusing. A defusing is for those directly involved or affected by the traumatic event (Mitchell & Everly, 1995a). Defusing occurs as soon as possible after the traumatic event (usually within 12 hours), it is not as formal or structured as a debriefing, is shorter in duration and is usually held in small groups. It does not thoroughly review the traumatic event that has just occurred, as it is too soon for most people to deal with, but it does help people cope with the initial intense responses to the event. Defusing can provide immediate assistance with practical necessities, like food, shelter, support and medical attention. A defusing can also be used to gauge if a formal debriefing may be needed for the emergency or medical workers (Mitchell & Everly).

Williams and Nurmi (1997) make clear the debriefing process is not psychotherapy, but a programme conducted by trained team members and are led by a trained mental health professional. It should be conducted within 24-48 hours after a traumatic event, with groups no larger than 15 people. Debriefing is not counselling either. There are aspects of counselling with the discussion of feelings and emotions, but this is balanced with talking about the facts of the event, what occurred, peoples' thoughts at the time, and the provision of some form of stress management. "One of the advantages of debriefing is that the structure encourages a better understanding of the experience in question, by separating the telling of the story from the feelings generated by the incident" (Parkinson, 1997, p. 79). Parkinson thinks debriefing offers people a cognitive restructuring of the traumatic event, so that they can make sense of their situation. The debriefing should also resolve some of the confusion people experienced and help them understand possible future psychological reactions in the future.

For the purposes of this study, the four main models of group debriefing that will be described are Mitchell's (1983) Critical Incident Stress Debriefing model, Raphael's (1986) and Dyregrov's (1989) models of Psychological Debriefing, and the Multiple Stressor Debriefing Model of Armstrong, O'Callahan and Marmar (1991). It should be noted some of these models have been adapted for use with individuals too. These debriefing models have a number of features in common. "The debriefing usually

occurs shortly after exposure to a traumatic event and involves sharing of factual information about the event and any emotional responses to it" (Canterbury & Yule, 1999, p. 226). However, these models also differ in their techniques and in some of their content, which to Canterbury and Yule suggests a lack of agreement about the necessary elements that make up a debriefing intervention.

The Mitchell Model

The realisation that emergency workers themselves experience substantial levels of traumatic stress, led some practitioners to develop intervention strategies specifically for emergency workers (Norris & Thompson, 1995). In 1983 Jeffrey Mitchell developed a stress management programme called Critical Incident Stress Debriefing (CISD), based on his experiences as a fire-fighter/paramedic. While it is not the only debriefing approach (Armstrong et al., 1991; Dyregrov, 1989; Raphael, 1986; Talbot, Manton, & Dunn, 1995), it is possibly the most recognised intervention strategy.

It has often been thought that emergency service personnel were trained not to react to human suffering and death, and they would not experience the turmoil that affected trauma victims. Mitchell and Dyregrov (1993) argue that this idea lacks a comprehension of how people react to stress, including emergency service personnel. They go on to say that it is these ideas continue the erroneous belief that training can prevent severe stress reactions in experienced emergency personnel, involved in traumatic events.

Mitchell and Everly (1995a) define a critical incident as any event that has a stressful impact, which is strong enough to overwhelm someone's coping abilities. Critical incidents are usually unexpected, powerful events, which are rare in occurrence. Critical incident stress (or traumatic stress) is the reaction a person has to a critical incident. Mitchell and Everly (1995a) report examples of critical incidents can include assaults, serious injuries, threatening situations, suicides, disasters and deaths. Solomon (1995) points out that critical incidents can raise stressful issues, such as facing one's own mortality and accepting the idea that terrible things can happen to anyone,

including oneself. A critical incident is the same as a traumatic event. Therefore, the phrase critical incident will be used from now to avoid confusion.

CISD is a structured programme for the management of stress in the emergency services. It is a psychological and educational support group discussion, facilitated by a specially trained team of health professionals. It is to be conducted with groups of people, not individuals. The two main goals of CISD are to reduce the impact of a critical incident on those exposed to it, and to accelerate the return of personnel to their regular functioning after the critical incident, before stress reactions become damaging to careers, families and peoples' health (Mitchell, 1988). CISD does not suggest that all who are involved in a critical incident need help. CISD assumes that after a critical incident most people will cope, but they will recuperate faster if they have an organised programme to follow (Parkinson, 1997). Over the last ten years, the variations that have arisen out of Mitchell's original CISD model provide evidence of the model's flexibility and popularity (Norris & Thompson, 1995), or if nothing else, it's appeal.

Mitchell and Everly (1995a) emphasise CISD has not been developed to resolve psychopathologies or personal problems which were present before the critical incident occurred. It has been devised for the strict purpose of preventing or mitigating the development of post-traumatic stress among high-risk professions, such as emergency services personnel. However, it can be a good source for detecting people with psychological problems and referring them to the appropriate people. CISD is a specific model of debriefing put together by Jeffrey Mitchell, thus CISD does not refer to all debriefing models, as each is slightly different in its structure.

Everly and Mitchell (1995a) point out that the CISD programme has been used by a range of occupational and social groups, such as the clergy, schools, lifeguard services and bank tellers. It has also been used in major disaster situations, including Hurricane Andrew in Florida in 1992, and the 1993 and 1994 civil unrest in Somalia.

The summary of the CISD programme and its protocol is from Mitchell (1983, 1988) and Mitchell and Dyregrov (1993). Initially, the 1983 CISD Mitchell model consisted of six phases, took up to five hours to complete and follow up services were performed several weeks or months after the critical incident. Since then, a refinement of the

CISD model has occurred and additions have been made to the original model. The CISD model now has seven phases and follows this summarised format:

Introduction Phase – the team leader introduces the debriefing team. Participants are told the purpose of the debriefing. The debriefing rules are explained and the importance of confidentiality is also stressed at this time. Participants are encouraged to talk but don't have to.

Fact Phase – the team leader asks the participants' to describe themselves, the critical incident and their role in the incident from their own perspective, to provide a clear picture of what occurred during the incident. It is an easy phase for people, as facts are impersonal and not upsetting to talk about.

Thought Phase – participants are asked to personalise their experiences. The facts now turn in to the significant memories of that person and how they experienced that incident. It is moving from relating to the facts of the situation, to developing a personal perspective on them.

Reaction Phase – any significant emotional feelings attached to the critical incident will usually be discussed here. This phase allows people to discuss any emotions associated with the event in a controlled environment. It enhances the venting of thoughts and feelings associated with the event. The CISD team don't need to speak much in this phase.

Symptom Phase – the debriefing group is asked to describe any stress symptoms they experienced during the incident, a few days after the incident and any symptoms that may still remain up to the time of the debriefing. The debriefers can use this time to determine if peoples' symptoms are worsening or lessening, and assess a person's coping abilities, and if they need any additional help.

Teaching Phase – information is provided about the normal nature of the stress symptoms and any future stress symptoms people may experience. Information is also shared on; reducing the impact of stress, the grief process, communication with partners and how to help one another.

Re-entry Phase – in this final phase, participants can ask the debriefers questions. The CISD team will usually instil some confidence back into the participants and give a summary of the debriefing to clarify any issues and provide closure to the debriefing. The whole process takes around two to three hours to complete.

Afterwards, team members move toward anyone who showed significant signs of distress during the debriefing. The CISD team then has a post-debriefing meeting to quickly review the debriefing and discuss what was done and ways to improve their techniques for future debriefings. But most importantly, it is to make sure everyone on the debriefing team is feeling fine. This meeting is an important safeguard for the team members' own well being.

Mitchell and Everly (1995a) make it clear that when a debriefing is over, that is not the end of the stress management programme. All debriefings must be followed up. Follow-ups usually begin 24 hours after the debriefing, and can include; telephone calls, visits to the workplace by peers, chaplain visits, educational programmes, and referrals to counselling sessions for individuals, couples or families. Follow-up meetings can also be held. Follow-ups are crucial to completing the work begun in the CISD. Without follow-up, symptoms may return for some people, whilst others may feel left alone or not cared for.

The debriefing team consists of one trained mental health professional and between one and three trained peer support personnel (Mitchell & Everly, 1995a). Talbot, Manton and Dunn (1995) emphasise that the formal CISD needs to be led by an experienced professional because the range of emotions expressed during the debriefing could unsettle an untrained team leader. Professionals also provide leadership and supervision, and can see when people are struggling with serious problems and in need of further help. Mental health professionals who have chosen to work with emergency service personnel should have a good background in group dynamics (Mitchell, 1983), issues of stress, PTSD, the nature of emergency services work (Mitchell & Dyregrov, 1993), and have at least a master's degree in a health profession (Everly & Mitchell, 1995).

There are three reasons why using peer support personnel is essential when doing debriefings with emergency personnel; peers provide familiarity with the nature and culture of emergency services (as well as providing a relevant credibility), peers can offer rapid intervention, and they can also present advice on effective coping strategies and stress management techniques that are appropriate to the profession (Mitchell & Everly, 1995a; Solomon, R., 1995).

Mitchell (1983) believed in most cases, a formal CISD should not be organised for the first 24 hours. Mitchell thought people are still too unsettled to be able to deal with an in-depth group discussion of the critical incident. He also states from his own experience, emergency services personnel are taught to restrain emotional reactions to do with the incident (to help them think clearly and function at a traumatic scene). At this time, Mitchell also insisted that the debriefing must take place within 24 to 72 hours of the critical incident. More recently however, he has acknowledged that this time period may need to be more flexible (Canterbury & Yule, 1999; Dyregrov, 1997; Raphael, Wilson, Meldrum, and McFarlane, 1996). Mitchell (1983) also believed the formal CISD should be mandatory for all personnel involved at the scene. But again, his opinion has changed, and now suggests personnel involved in a critical incident (and supervisory staff) should be invited to go to the debriefing.

Mitchell and Everly (1995a) summarise the co-ordination that needs to be done to hold a debriefing. Supervisors of the people involved in the critical incident should encourage these people to go to the debriefing. The CISD team needs to undertake a review of the critical incident before the debriefing begins, to familiarise themselves with the incident and to enhance the effectiveness of the CISD. The debriefing team will also decide on a plan for the debriefing. The team leader is the mental health professional assigned to the debriefing. A date and a time are set for the debriefing that is appropriate for those participants involved. When there are a lot of people to be debriefed, relevant groups need to be created. Those most affected by an incident are the priority group, those directly involved are the next priority, and so on. The ideal debriefing size is between 4-20 people.

Mitchell believes people in a debriefing tend to feel more comfortable when a CISD comes from people the debriefing participants' do not see or work with regularly. Otherwise the lack of familiarity with the mental health professionals can create a gap in credibility, which can lead to mistrust, resistance and anger, argue Mitchell and Dyrgrov, (1993). Another key point made by Mitchell and Everly (1995a) is that the overuse of CISD on minor events is not using the programme correctly, as this will diminish its effectiveness and it will not be beneficial during serious critical incidents, (with emphasis on the word critical).

It needs to be highlighted that the CISD programme is one facet in a comprehensive stress management programme called Critical Incident Stress Management (CISM). Using CISD outside of the context of CISM could be beneficial, but it lacks the effectiveness it could have when supported by other complimentary and essential interventions (Mitchell, 1995). Mitchell then wisely acknowledges that any stress prevention programme that relies solely on one particular intervention will probably not achieve its desired goals.

The components of CISM can be roughly divided into three main segments, and are summarised here using Mitchell's (1995) article. The first segment is the pre-exposure stress management section. It is made up of; screening and selection of personnel, orientating staff to their job before they begin, clarifying employee job expectations and responsibilities, stress education (in preparation for any stress in their work or personal lives), and ensuring organisations have plans and policies established, if and when critical incidents should occur. The second component, CISM strategies during traumatic exposure, revolves around what is called 'on scene' support services. These services provide practical aid to help people get through a critical incident.

The final segment is the post-intervention stress management phase, which includes, demobilisation (in the case of large scale disasters), defusing, CISD, and all the levels of help within each of those programmes, which makes CISM quite impressive. The basic CISD model has now been partially modified for mass disaster/community response applications, which are examples of prolonged trauma and/or repeated trauma. The obvious changes to the format are in phases three, four and five (Mitchell & Everly, 1995b). Thus the CISM programme is constantly evolving. The CISM and CISD programmes each go into more detail. However the present study has provided a clear outline of these programmes.

Possible reasons for CISD effectiveness, according to Mitchell and Everly (1995a), include; its early intervention, opportunity for catharsis, group support, peer involvement, stress education and follow-up services. Solomon (1995) adds that CISD is successful because it provides; information on coping with current and future stress, early detection of people with other psychological problems, a cost effective programme and the opportunity for a happy and healthy work environment to be created.

Mitchell and Everly (1995a) consider the 12 years of clinical experience and anecdotal evidence, they and others have gathered, to be an accurate gage of CISM's value as a stress intervention programme. Despite a lack of positive outcome literature on the efficacy of CISD, the CISD intervention has become widely utilised in its 12 year history with over 400 CISM teams worldwide. However, CISD will need more than anecdotal evidence and popularity to cement its place as an effective preventive intervention programme.

Other Debriefing Models

According to Robinson (1995), "Professor Beverley Raphael was a pioneer in developing understanding of the impact of disasters on emergency services personnel" (p. 95). Peoples' emotional experiences are a large part of Raphael's model (Everly, Flannery, & Mitchell, 2000). This model addresses the satisfaction and frustration with disaster work. Raphael (1986) also draws attention to any positive aspects of the disaster a worker may have experienced the need for, and integrating a positive and negative perspective of the disaster. Unlike the other models, this model involves discussing peoples' previous training (if any), previous disaster stressors. In addition, this model also dismisses interpersonal relationships (Everly et al., 2000), the uniqueness of their work (Raphael, 1986) and adjusting back to regular life (Rose, 1997). Therefore Raphael's model stresses the importance of addressing the relationships of the workers with their colleagues, family and the victims, and understanding and dealing with the traumatic event, so it won't become an issue in the future (Canterbury & Yule, 1999).

Process debriefing (PD) is another model of debriefing devised by Dyregrov (1989). It is based on the same seven phases Mitchell (1983) uses in his model. However, Dyregrov's model "focuses on the decision-making process of the participants during the thought stage...and places emphasis on the normalisation of reactions and responses"(Everly et al., 2000, p. 26). A few group processes need to be used and understood for the debriefing to be effective. These include total support and participation by all group members, and the importance of the group normalising others' reactions to the traumatic event (Canterbury & Yule, 1999).

Dyregrov (1997) agrees with Mitchell and Everly (1995a), that the make up of the group is important. Groups could be set up to reflect peoples' similarity in their experience of the critical incident, similarity in their profession or geographical location. The Dyregrov model takes 2-4 hours to complete and prefers a rectangular seating arrangement as opposed to Mitchell's (1983) model, that sits in a circle (Dyregrov, 1997).

The fourth model to be discussed is the Multiple Stressor Debriefing Model (MSDM) developed by Armstrong, O'Callahan, and Marmar (1991). It is a one session, group or individual intervention (Armstrong, Zatzick, Metzler, Weiss, Marmar, Garma, Ronfeldt, Roepke, 1998). It was put together as a result of the authors' work with American Red Cross personnel following the 1989 San Francisco earthquake. Red Cross workers' roles were seen as different to that of traditional rescue workers, whose work is usually focused, intense and brief (Armstrong et al., 1991). The main difference from earlier models is that this model addresses the reality that "disaster relief workers are often faced with multiple stressors over a prolonged period" (Canterbury & Yule, 1999, p. 225).

The main idea behind the MSDM model is that disaster workers are not dealing with a traumatic event, but many events. These events can require weeks of work, involving long hours' every day. Armstrong et al., (1991) believe "it is these long hours working with trauma victims under difficult conditions that places them at risk of developing stress reactions, including PTSD" (p. 582). Many disaster workers work in shifts, so do not have a lot to do with workers in other shifts, yet they are all dealing with the same disaster. Also, disaster work involves large numbers of people to co-ordinate (who can potentially be traumatised) in a variety of roles. The MSDM is based on Mitchell's (1983) model, but also has features of Raphael's model too. It involves four stages; disclosure of events, which could involve several events per person; feelings and reactions; coping strategies and termination, which involves goodbyes and preparation for the transition home (Canterbury & Yule, 1999)

Evaluation Research

The results of the evaluation studies conducted on psychological debriefing have produced mixed findings. This section will review the evaluation literature, and will end with recent review studies on debriefing's effectiveness.

A large number of uncontrolled and comparison studies have been undertaken, that support the effectiveness of psychological debriefing with primary and secondary victims of critical incidents. Most of these studies used group debriefing. Robinson and Mitchell (1993) used questionnaires to evaluate debriefings on 172 emergency, welfare and hospital workers. Both sets of workers rated the debriefing as considerably valuable for themselves and the group. Welfare/hospital staff reported higher symptoms of stress (84%), than emergency service personnel (44%) at the time of the incident. However, both groups reported large reductions in these stress symptoms at the two-week follow-up evaluation, which they ascertained was due, in part, to the debriefing. Debriefing was considered helpful because people could talk about the incident, and with others who had experienced it. However, 41% of welfare/hospital staff were still strongly affected by the incident by the time of the evaluation. Armstrong et al. (1998) found Red Cross workers also rated the Multiple Stressor Debriefing Model (MSDM) positively, in a questionnaire assessing the effectiveness of individual and group debriefings. Ninety-five workers responded to the questionnaire, one month after leaving the site of a major earthquake. These studies provided no standardised measures to assess stress symptomology. There was also no control group or any follow-up assessments.

A descriptive study was conducted by Burns and Harm (1993) to determine the usefulness of critical incident stress debriefings on emergency nurses. Only one third of the participants had been to a debriefing, and most of the nurses reported these debriefings to be helpful to them. Burns and Harm also state the support of management for debriefings is important for nurses to participate in them.

After the Kings Cross Fire in a London underground, Turner, Thompson and Rosser (1995) investigated the scale of psychological distress and the role of individual debriefing on a sample of 50 passengers, emergency services personnel and

underground staff. Interviews and assisted completion of the questionnaires took place between 1 and 12 months after the fire. The questionnaires showed most of the sample exhibited psychological distress. The data also revealed 81% of the 43 people who were able to talk soon after the fire to family or friends ('spontaneous' debriefing), found it helpful. The small sample size and varied times at which participants were assessed, are limitations of this study. Also, the definition of debriefing used here is not the one usually referred to by researchers investigating debriefing.

Lane (1993-94) wrote a descriptive study based on a CISD model in place in a hospital and medical centre in Arizona. Interviews were conducted with female healthcare workers. All debriefings that were referred to were group orientated and focused on staff reactions to incidents where a patient died. Debriefings were viewed as extremely helpful and were seen to increase communication and mutual support between staff. Lane believes the CISD programme in this hospital indicates short-term benefits for staff, but the long-term effects are, as yet, unknown.

Flannery, Hanson, Penk, Flannery, & Gallagher (1995) developed a model called 'The Assaulted Staff Action Programme' (ASAP). It was designed to deal with any psychological symptomology that could develop after duty-related, patient-staff violence, in a state mental hospital. It uses a CISM approach and is made up of staff volunteers. Initial evaluations indicated the presence of trauma symptoms in many of the staff that were assaulted. A large reduction was noticed in the ASAP programme being requested by staff,over a five month period. During the time the programme was run, only one staff member resigned due to workplace violence, as opposed to an average of 15 per year before ASAP. The UK Post Office also developed a CISM based model (Tehrani, 1995). The Core Trauma Care Programme was put in place for postal employees involved in critical incidents. The programme involves five stages of crisis management, debriefing, evaluation and follow-up, with a pre-incident stage covering employee selection and education. Anecdotal reports suggest that management and staff are favourable towards the programme.

Stallard and Law (1993) conducted debriefings with seven children and one teacher, six months after they were involved in a minibus accident. Two debriefing sessions were held one week apart, each was three hours long. A PTSD screening battery was

completed before the initial debriefing, and followed up three months later. The results of the first battery indicate the participants were experiencing distress with intrusive thoughts and feelings of anxiety and depression. However, these were all significantly reduced at the three-month follow-up, which can be attributed, in part, to the debriefing. The use of objective outcome measures was an asset to the study, but the small sample size and lack of control group does limit these findings. This study is interesting in that it provides two debriefing sessions, rather than the usual one session.

A comparison study was conducted by Chemtob, Tomas, Law, & Cremniter (1997) after a hurricane that struck Hawaii. The first group was debriefed six months after the hurricane and comprised 25 staff of a temporary counselling programme. The second group of 18 people were staff members of a local mental health centre who received debriefing nine months post-disaster. Both groups were followed up three months after their debriefings. A significant reduction in IES (Horowitz, Wilner & Alvarez, 1979) scores was found in both groups, after debriefing, which implies the decrease in distress is partly due to the debriefing. A possible limitation to this study is the use of only one objective outcome measure. This study, and the one by Stallard and Law (1993) were unusual in that they provided debriefing six and nine months after the incident, instead of conducting them within one month, which seems to be the average time researchers use.

In 1986, Solomon and Benbenishty investigated the effectiveness of the frontline treatment provided to Israeli soldiers in a quasi-experimental design. The treatment was based on the principles of proximity, immediacy and expectancy, and was thought to reduce long-term psychiatric sequelae. The sample comprised a few hundred soldiers with combat stress reaction, who filled out a battery of questionnaires, one year after the Lebanon war ended and treatment was given. Allocation to groups was done by the army and was unintentionally random. The results demonstrated that a soldier's rate of return to duty was strongly related to these three principles. When the three principles were not employed, 71% of soldiers presented with PTSD and only 22% returned to their unit. Therefore, it was concluded frontline treatment for combat stress reaction appears to be successful. Yet, one year after the treatment programme, even though 60% of soldiers had returned to their unit, 40% had developed PTSD. This indicates that treatment may help reduce the incidence of PTSD, but not prevent it.

There are other authors who endorse the benefits of debriefing due to their own experiences with it (Dyregrov, 1997; Parkinson, 1997). Bell (1995) proposed setting up specific teams to provide the delivery of debriefing to different groups. Talbot et al. (1995) developed a model for debriefing psychologists, who provide debriefings for others. Debriefing is also perceived to be important from an organisational perspective (Mayhew, 1997). Williams and Nurmi (1997) recommend debriefing when a co-worker has died. They see it as a necessity to be provided by an organisation, especially if an organisation is likely to be vulnerable to critical incidents. Solomon (1995) also endorses this organisational perspective with regard to law enforcement personnel.

In the literature, there is another group of studies that suggest that psychological debriefing does not work. The first three studies to be mentioned are all comparison studies. The effects of debriefing on the rate of recovery of 195 helpers (emergency service personnel and disaster workers) was evaluated by Kenardy et al. (1996), one year after an earthquake. Of the 62 people who were debriefed, 80% of them found it somewhat, very or extremely helpful. There was a significant reduction in both groups scores over the two year follow-up evaluations on the IES. The debriefing group had significantly higher overall scores on the GHQ-12, over the non-debriefed group. Kenardy et al. (1996) concluded that the rate of recovery was not more rapid in the debriefing group compared with the non-debriefed group. However, this investigation had no random allocation of participants, or standardisation of the debriefing model or its procedures, and was made up of a sample that mixed professionals with volunteers.

In Matthews (1998) study of the efficacy of CISD in mitigating post-traumatic stress in psychiatric workers, no difference was found between those who were debriefed and those who weren't. The 63 workers who volunteered to participate (no random allocation) were given a survey to fill out, one week after the critical incident occurred. Workers were assigned to one of three groups, but only one of the groups received a debriefing. Over half the people who were debriefed rated it positively. Distress did decrease for all the groups in the period between the incident occurring and the survey being completed. Nevertheless, the debriefing group exhibited higher ratings of stress symptomology than the group that chose not to attend a debriefing.

Deahl et al., (1994) studied the effect of debriefing on psychological morbidity in 62 British soldiers who served during the Gulf War. Due to operational reasons and not random allocation, only 42 soldiers received a debriefing at the time of the war, therefore setting up a control group. Twenty of the debriefed group indicated the debriefing was helpful. Results from the questionnaires (sent out nine months after the soldiers returned home), show the debriefed group's IES and GHQ-28 scores were not different from the group that weren't debriefed. Half of the participants were still experiencing psychological sequelae, so debriefing did not considerably reduce morbidity. Yet the authors still stand by the principle of debriefing due to their clinical experience with it.

In the last five years, random controlled trial (RCT) studies have begun to emerge. All of the following studies have mainly focused on individual debriefings, with primary victims of critical incidents. One of the first randomised control trials was conducted by Lee, Slade and Lygo (1996) to assess the effectiveness of debriefing on 39 women who had experienced a miscarriage. Half the women received a debriefing two weeks after their miscarriage. Baseline data collected one week post-miscarriage indicated psychological distress in most women with 11 reaching the threshold for anxiety caseness and 3 exhibited depression caseness. Scores on a post-traumatic symptoms scale were also elevated. The debriefed group appeared to be generally happy with the debriefing and appreciated the opportunity to talk to someone about the experience. Distress scores at four months on all measures, for both groups, were significantly reduced. Therefore Lee et al. found no ill effects or difference in outcome between the debriefed and non-debriefed groups. However, the small sample size and lack of standardisation of debriefing procedures may have affected the significance of these results.

An investigation was conducted into the psychopathology of 106 road accident victims (Hobbs, Mayou, Harrison, & Worlock, 1996). Debriefings were provided for 54 people, within 48 hours of their accident. Initial data showed the debriefed group had a higher mean injury severity score and spent longer in hospital than the control group. At the four month follow-up, psychopathology was present in both groups, with no significant reduction in symptoms, indicating debriefing had not had any effect. Lee et al. (1996) also found this in their study. Mayou, Ehlers, and Hobbs (2000) conducted a follow-up

study three years later. Sixty-one people responded and the intervention group were significantly worse on some of the original psychological and social outcome measures. It is even suggested that the individual debriefings could have made people worse. Conlon, Fahy, and Conroy (1999) examined debriefing's role in the recovery of 32 road accident victims. Baseline data and debriefings were organised within two weeks of participant's accidents. Within two weeks of the accident, psychopathology was experienced by 75% of the total sample. By the three-month follow-up, all participants exhibited reductions in symptoms across all measures. However, PTSD was still present in 19% of the participants, and 35% of the participants still rated themselves as significantly distressed.

One hundred and three burn victims responded to a questionnaire evaluating the ability of debriefing to reduce psychological sequelae (Bisson, Jenkins, Alexander, & Bannister, 1997). Participants were randomly allocated to an individual/couple debriefing group or a control group. Debriefings took place within three weeks of the burn trauma. Baseline evaluations showed that the debriefed group had suffered more previous traumas and the factors involved in their present trauma were more extreme than with the control group. Both groups' scores on various outcome measures were similar and indicated psychological distress. At 13 months, the debriefed group was significantly worse in all of the outcome measures, and had higher rates of PTSD, than the control group. Yet, it should be remembered that the debriefed group had higher dimensions of trauma than the control group before the debriefing, which is often associated with a poorer outcome.

Hobbs and Adshead (1997) both carried out prospective RCT studies. The first study involved a mixed group of 63 (42 at follow-up) accident, assault and dog bite victims. The second study focused on those with injuries from road accidents. Both studies conducted debriefing within 24 hours of attendance at a hospital and provided follow-up to the initial evaluations. Results of the first study showed no difference in the outcome measures between the intervention and control groups, with most people's psychiatric symptoms abating at follow-up. Sixty six percent of the intervention group found the debriefing useful. The second study of 114 road accident victims (86 at follow-up) also found no significant differences between the control and intervention groups. However, there was data in this study, as indicated by some of the outcome measures, that

suggested there were possible increases in psychiatric morbidity in the intervention group.

Two interventions were used by Rose, Brewin, Andrews, and Kirk (1999), to assess 157 victims of violent crime who wanted to talk. Participants were assigned to an education group, a debriefing and education group or an assessment only group, within one month of the crime. Results indicate no significant difference in outcome measures in the education group or the debriefing and education group. PTSD was diagnosed in 28 of the participants after six months. Yet there was a gradual improvement on all outcome measures across all the groups at the 6 and 11 month follow-ups. No evidence was found to support the efficacy of these interventions in preventing or affecting negative psychological reactions.

Debriefing has also been used to reduce depression six months after operative childbirth. Small, Lumley, Donohue, Potter, and Waldenstrom, (2000) used midwives to conduct the individual debriefings on 917 women. Results show the debriefed group fared no better than the standard care group. But, the debriefing was rated as helpful or very helpful by 94% of the debriefed group. A few measures hinted at a worse outcome for the debriefed group, but all results were non-significant. The authors in this study did not state which model or structure their debriefing was based on, except to say talking and empathetic listening was used. Also, debriefing was developed to mitigate PTSD, not depression.

Other authors who believe there is a lack of evidence supporting the effectiveness of psychological debriefing include; Bisson and Shepherd (1995), Kenardy (2000), Kenardy and Carr (1996), Mitchell (1999), Rose (1997), Shalev (1994), and Stephens (1997). Some authors are more specific in their criticism and believe the CISD model is not effective, with more evaluation needed (Watts, 1994), in the form of RCT's (Bisson, 1997). Yamey (2000) argues that psychological debriefing is ineffective within industry settings and it could potentially be harmful.

The last group of studies reviewed the evaluation literature on debriefing, and discussed the methodological problems with conducting debriefing research, and the current issues facing psychological debriefing. Bisson and Deahl (1994) were one of the first

groups of authors to conduct a review of the literature on debriefing. They concluded that much of the research into debriefing was methodologically flawed and debriefing had not been proven to decrease psychological sequelae. Both of the reviews conducted by Raphael, Meldrum, and McFarlane (1995) and Raphael et al. (1996), strongly recommended the need for more rigorous research in evaluating debriefing and for RCT's to evaluate debriefing's effectiveness. They also considered the possibility that debriefing could be detrimental to those who receive it.

A systematic review of brief, early psychological interventions was conducted by Rose and Bisson in 1998. Criteria for the inclusion of studies in this review, were the use of RCT's, standardised and valid measures, provision of the intervention within one month of the trauma and provision of a structured intervention. Six studies fulfilled the criteria and all were individual or individual/couple debriefings. Two studies found a positive outcome, two showed no overall effect and two had a negative outcome. In three of the studies, those who had received debriefings perceived them as useful. Overall, the results indicated debriefing had little impact in preventing psychopathology. Wessely, Rose, and Bisson (1999) conducted a similar study with almost the same criteria that Rose and Bisson (1998) used. Eight studies matched their inclusion criteria; again all were individual RCT's. Due to methodological shortcomings, two studies were excluded from the main analyses. The majority of the studies indicated that debriefing did not appear to reduce psychological distress in the short-term, and it was not found to be successful in preventing PTSD.

Canterbury and Yule (1999) provide a thoughtful discussion on the role of psychological debriefing in preventing PTSD. They believe current evaluative literature on debriefing hasn't proven debriefing to be effective in reducing psychological morbidity following trauma. However, there is a lack of empirical investigation into group debriefing. Canterbury and Yule also highlight the need to standardise procedures and conduct more RCT's, but advise caution in the use of debriefing.

Everly, Boyle, and Lating (1999) conducted the only meta-analysis of evaluation literature, and the only review on group debriefing with secondary victims, known to this author. The ten studies that were included were from a pool of adequately controlled, peer reviewed journal articles or clinical proceedings. A significant positive

mean effect was found upon pooling all the studies effective sizes. This equates to debriefing being found to have a beneficial effect on mitigating symptoms of psychological distress. These results indicate good generalisability, as the sample included 698 people from different jobs, who experienced a variety of critical incidents and were assessed using a range of outcome measures.

The two most recent reviews are by Everly et al. (2000) and Deahl (2000). Everly et al. discuss the strengths and weaknesses of the CISM literature, including methodological issues. The review of the debriefing literature is quite extensive and ends with four conclusions. Firstly, critical incidents that result in psychological distress occur frequently. Secondly, CISM interventions may effectively address psychological symptomology after critical incidents. Thirdly, more empirical research is needed. Finally, support from management is crucial for the implementation of the CISM intervention and to ensure evaluation is conducted.

Deahl's (2000) review is probably the most comprehensive and fair discussion of the history and current issues in psychological debriefing. Deahl examines the role debriefing plays in preventing long-term psychiatric morbidity, such as PTSD, in conjunction with the generally negative findings. He elaborates on the difficulties in undertaking research in this area, and the idea that has developed recently, that RCT studies are the only viable option in evaluative research for debriefing. Deahl concludes that the effectiveness of debriefing to reduce psychological sequelae is still uncertain, as most of the studies evaluating this were methodologically flawed. There needs to be standardisation of debriefings aims and procedures. Debriefing appears to provide some short-term benefits, but long-term benefits are unknown. He believes PTSD should not be used as the only measure of successful outcome, and a one off debriefing session will never be sufficient to alleviate psychological distress on its own.

Methodological Issues in Evaluation Literature

Psychological debriefing is a popular and widely used intervention. Yet it is a contentious area in trauma literature and research, and with the health practitioners (Kenardy, 2000) and groups who use it. Demonstrating the effectiveness of

psychological debriefing has not been easy (Bisson & Deahl, 1994; Deahl, 2000). There is a scarcity of empirical evidence supporting the effectiveness of psychological debriefing in reducing psychological distress (Bisson & Deahl, 1994; Bisson & Shepherd, 1995; Canterbury & Yule, 1999). This section discusses a few of the reasons why debriefing is hard to evaluate, and some of the inconsistencies in the current literature on psychological debriefing.

The key word here is empirical, as a lot of anecdotal research (questionnaires, self reports and case studies) has been conducted during the 1980s and 1990s on psychological debriefing. Yet few studies meet the criteria of evaluative research paradigms (Moran, 1998), so there is not much empirical (objectively measured) information available on the nature of change following CISD. In saying that, research into the effectiveness of debriefing is not a straightforward issue, as achieving sound empirical or anecdotal evidence can be difficult and complex (Williams & Nurmi, 1997). For instance, for a debriefing to occur, a critical incident needs to take place, which in itself is usually unexpected and very distressing for those involved. Everly, Flannery and Mitchell (2000) agree that when a critical incident occurs, peoples' attention is on helping those affected, not necessarily on research and achieving a sound methodology. Some factors that influence the ability of researchers to thoroughly investigate the efficacy of psychological debriefing include; the type of critical incident, the situation it occurs in, when it occurs and whom it effects.

The issue of doing more research into psychological debriefing isn't as simple as increasing the amount of studies on debriefing or the number of randomly controlled trial studies. Much of the published literature has a range of methodological problems (Bisson and Deahl, 1994; Deahl, 2000, Stallard, 2000). A summary of these issues will now be provided.

Researchers must be clear about what they are evaluating, their aims and their methodology. One criticism of the existing literature focuses on the type of research used to evaluate psychological debriefing. One of the most common types of research that is utilised is self-reports, such as questionnaires, surveys or case studies. These can be referred to as anecdotal evidence. Many authors stress there is a lot of anecdotal evidence into the effectiveness of psychological debriefing (Armstrong et al., 1998;

Bisson & Deahl, 1994; Canterbury & Yule, 1999; Parkinson, 1997; Robinson & Mitchell, 1993). Yet Kenardy and Carr (1996) believe this evidence is not good enough, and there is a need for empirical research. Recently, researchers have been recommending empirical research, in the form of RCT's, as the way to vigorously evaluate debriefing (Canterbury & Yule, 1999; Raphael et al., 1995; Rose, 1997; Wessely, Rose, & Bisson, 1999).

Deahl (2000) explains one view on the issue of debriefing research. It is really only in the last five years that psychological debriefing has been subject to RCT's, as these are now viewed as the principal type of research to be conducted on debriefing, whilst seemingly ignoring anecdotal research. However, anecdotal research is still relevant, but Deahl acknowledges this type of research is usually conducive to problems with sample selection and random allocation. He also warns that if strict scientific evaluation rules are established for debriefing research, large amounts of relevant information could be lost, as the RCT method should not be the sole source of evaluation research regarding psychological debriefing.

Numerous studies evaluating psychological debriefing do not state which debriefing technique they are using or referring to (Chemtob et al., 1997; Hobbs et al., 1996; Kenardy et al., 1996), what the debriefing entails (Deahl, 2000), or what training, if any, the debriefers received (Everly et al., 2000). An author simply stating in their research that a debriefing was conducted doesn't provide enough information to provide replication or generalisability across studies.

Each of the models of psychological debriefing currently in use have different aims, some are more similar than others (Shalev, 1994) The variety of aims makes it hard to measure their effectiveness when they are all trying to achieve different goals (Moran, 1998). If a debriefing is supposed to provide emotional support and stress education, it is perceived to do this well by those who receive the debriefing (Moran, 1998; Robinson & Mitchell, 1993). If the goal of the debriefing is to mitigate post-trauma reactions, and minimise the development of PTSD, the results are not so positive about debriefing (Moran, 1998). A number of researchers even go so far as to suggest that debriefing could have negative effects (Bisson et al., 1997; Hall, 2000; Mayou et al., 2000;

Raphael et al., 1996; Yamey, 2000). If well-defined and consistent aims are not put in place, evaluation of debriefing models is impossible (Mitchell, 1999).

Every critical incident is different. Therefore, it does not make sense when researchers assemble various types of critical incidents together, and compare the victims' psychological reactions (Deahl, 2000). This does not take into account the different levels of severity or distress different incidents can cause. For example, Stevens and Adshead (1993, cited by Hobbs & Adshead, 1997) compared victims of road accidents, assaults by a stranger and dog bites, and Small et al. (2000) sample comprised pregnant women who had elective or emergency operative childbirth. All of these incidents have different contexts and possibly different levels of guilt or blame for the victims. Also, people involved in critical incidents can be experienced emergency workers or voluntary workers with no experience, which could also affect people's level of distress. Busuttil and Busuttil (1995) believe distinctions need to be made between the different types of critical incidents that can occur. The type of incident may affect the type of debriefing model to be used. One debriefing model may be beneficial after a single critical incident (Robinson & Mitchell, 1993), whilst another model may be needed for a series of on-going traumas, which stem from one critical incident, such as in disasters (Armstrong et al., 1991; Armstrong et al., 1998).

Another shortcoming in debriefing research is the lack of random allocation to treatment groups (Matthews, 1998). It can't be ruled out that there could be a crucial difference between the results of those who choose to go to a debriefing and those who do not (Bisson & Deahl, 1994; Deahl, 2000). Random allocation minimises any extraneous variables.

As psychological debriefing is currently viewed as an important part of the care provided to trauma victims, it could be seen as unethical to withhold this form of assistance, due to the stringent rules of random allocation in RCT's (Everly et al., 2000). This is especially so when it is noted that most people want to attend a debriefing programme and find it to be a positive experience (Armstrong et al., 1998; Canterbury & Yule, 1999; Raphael et al., 1995; Robinson & Mitchell, 1993), at least in the short-term.

Another common methodological issue is that many studies have a post-test only design to assess change (if any) in people after attendance at a psychological debriefing (Everly et al., 2000). It is not right to make conclusions about a debriefing model's efficacy when there is no pre-test data on people's psychological functioning before the critical incident (Kenardy & Carr, 1996; Robinson & Mitchell, 1995). Pre-test data can demonstrate if clinical levels of psychological morbidity might already be present in participants. Thus, research that uses post-test only outcome measures cannot rule out the chance that a person's previous psychological morbidity or experiences of trauma could affect the results of that study.

Any research that evaluates debriefing without either a control or comparison group is limited in its generalisability. The lack of a control group in studies (Flannery, Fulton, Tausch, & DeLoffiet, 1991; Lane, 1993-94; Robinson & Mitchell, 1993) means understanding their results is difficult, as people naturally begin to recover from critical incidents (to a certain degree) in their own time, but at different rates, regardless of psychological debriefing (Bisson & Deahl, 1994). So not having a control group to compare any recovery with, makes the role debriefing played in someone's psychological change unclear.

In debriefing evaluation research, there tends to be a lack of standardisation in the choice of outcome measures (Everly et al., 2000). This makes comparisons between studies problematic, as researchers are assessing change in peoples' psychological well-being on many different scales, each with their own definition and levels of well-being.

Low response rates in questionnaires and surveys are another problem in debriefing research (Berah, Jones & Valent, 1984; Bordrow & Porritt, 1979, cited in Bisson & Deahl, 1994; Stallard & Law, 1993). Deahl (2000) emphasises that if a group of people do not see the point in having a debriefing, or don't believe it will work, they are less likely to co-operate in a study evaluating it. This attitude seems to be common with emergency workers/medical personnel, as these workers don't tend to ask for help often or believe that they don't need debriefing to cope with their stress (Beavan, 1998). A poor response rate means a small sample size, which has implications for that piece of research in the choice of statistical analysis to be used, the validity of the statistics and the generalisability of the study.

There are also other variables that can influence a person's psychological functioning besides the trauma of a critical incident. These variables are more about the people involved in the incident, and not the incident itself. For example, how people deal with stress, any past or present psychiatric disorders (Wessely et al. 1999), other current stresses in a person's life and the amount of social support a person has access to. Raphael et al. (1995) even suggests some of these variables could be one of the reasons why debriefing (as it is carried out now) isn't perceived to work.

Another set of issues researchers need to contend with, refer to the application of debriefing. In studies that do describe the debriefing technique that was used, the lack of standardised implementation of debriefing models again limits generalisability, as the models can vary so much (Deahl, 2000; Everly et al., 2000). For example, Kenardy et al. (1996) had no standardisation of the availability or the nature of the debriefing, and had to assume the debriefing was given in a fair and consistent fashion. It can also mean that when psychological debriefing is evaluated, different models are put together and compared to assess the efficacy of debriefing, instead of the efficacy of each debriefing model. The definition of what debriefing is, becomes even more distorted and inaccurate. The following quote is a good example of this problem.

> The point of our paper is that whatever it is that goes by the name debriefing, that is, whatever debriefers are doing out in the field, showed no evidence of efficacy. As outlined above, this is not the ideal test of the efficacy of debriefing, but in the absence of soundly designed, randomised controlled trials... it is all that we have (p. 6, Kenardy & Carr, 1996).

Most psychological debriefings are to be applied as one-session initiatives, to be used, (in the case of CISD), in conjunction with other preventive resources, like CISM (Turnbull, Busuttil, & Pittman, 1997). Yet researchers, such as Busuttil, Turnbull, Neal, Rollins, West, Blanch, & Herepath, (1995) and Stallard and Law (1993), have defined what they call debriefing as an initiative requiring more than one session (as in counselling). However, this changes the purpose of a debriefing and makes it a more ongoing process, like counselling, which it is not. Part of this issue is made more difficult when recent literature includes counselling in its definition of psychological debriefing (Kenardy, 2000). Labelling this kind of support as debriefing (no matter how

broad the definition) is confusing and incorrect (Mitchell, M., 1999; Robinson & Mitchell, 1995).

It is inappropriate to use a debriefing model with people it was not intended for, and then make inferences about the effectiveness of that model (Kenardy & Carr, 1996; Robinson & Mitchell, 1995). For instance, CISD was originally designed for emergency services personnel, yet it has been used on many other populations (Bisson et al. 1997; Lee et al., 1996; Parkinson, 1997; Rose, Brewin, Andrews, & Kirk, 1999). Debriefing models have also commonly been used with individuals, as opposed to groups (Bisson et al.; Lee et al.; Rose, 1997) and with primary, not secondary victims (Hobbs et al., 1996; Small, Lumley, Donohue, Potter, & Waldenstrom, 2000; Wessely et al. 1999). Models have also been used as part of a treatment programme, not just as a preventive aid (Busuttil et al. 1995). researchers

Also if people receive individual debriefings instead of group debriefings, (which most models are designed for), they are not experiencing the group processes that psychological debriefing was intended to provide. An important point to note is that individuals are also not exposed to others who have experienced that same critical incident (Busuttil & Busuttil, 1995) and this could be a vital part of the support system. Finally, primary and secondary victims may require different types of debriefing and support due to their varied experiences of the critical incident (Busuttil & Busuttil; Robinson & Mitchell, 1995). Therefore any conclusions about a debriefing model's validity should be amended to state that the model is inappropriate for certain people or that changes made to the model (or its use) did not work (Robinson & Mitchell). As important differences could arise when using the models on people other than the ones it was intended for (Busuttil & Busuttil).

In some cases, researchers are not following the rules stipulated within a particular model. For example, with CISD, Jeffrey Mitchell has often said this model should be used in conjunction with follow-ups and CISM procedures (Mitchell, 1983; 1988; 1995; Robinson & Mitchell, 1995), but it is often utilised as a stand-alone intervention. This makes it hard to maintain consistency, assess efficacy and make comparisons between studies. Even when a debriefing model has been named and well defined, researchers can't agree on the rules for any given model, as they are changing (as more is learnt)

with regard to the suggested number, frequency and timing (Kraus, 1997; Mitchell, M., 1999) of that particular intervention model (Dyregrov, 1997), as well as the role of additional resources to accompany it (Deahl, 2000). For example, existing research into debriefing provides inconsistency with the length of time between the critical incident occurring and receiving debriefing, and the length of time between receiving debriefing and an evaluation of its effectiveness. Further confusion arises when some authors state debriefings should occur 2-3 days after a critical incident (Dyregrov, 1997; Mitchell & Everly, 1995a), whilst others have implemented debriefing months later (Stallard & Law, 1993).

Researchers do not seem to know what the critical processes are that make up a successful debriefing, or which processes can promote a positive psychological change (Canterbury & Yule, 1999). In any given model, a variety of processes exist, such as social and emotional support, teaching acceptance of the critical incident, discussing shared experiences, emotional catharsis, normalising reactions, and/or information on how to cope with stress (Busuttil & Busuttil, 1995). Finding out what these processes are will improve the application of debriefing and hopefully improve its efficacy.

Differing views now exist over whether attendance at debriefings should be mandatory or voluntary (Mitchell, 1999). Most debriefing models encourage voluntary attendance. Nevertheless, one advantage to making debriefings mandatory is that the stigma of help seeking, that is strong in some work cultures, is lessened, especially if it becomes part of the policy of an organisation (Parkinson, 1993).

Several points can be concluded as a result of the evaluation literature and methodological issues related to psychological debriefing. Firstly, debriefing is a popular mental health preventive intervention, used in a range of professions and with a variety of critical incidents. There appears to be some subjective benefit in victims getting the chance to talk after being in a critical incident, as most studies have reported people find it beneficial. However, most researchers are cautious in claiming the effectiveness of debriefing to reduce psychological sequelae after critical incidents. Many believe it has no demonstratable effect. This is partly due to the lack of RCT studies being undertaken. This is a difficult area to research, so there are many issues relating to methodology and the application of debriefing, with studies that have been

conducted. Lastly, with regard to this study, there is not a great deal of published research on the debriefing of mental health staff, such as psychiatric nurses, occupational therapists or psychologists, who are secondary victims of trauma. An extensive literature search failed to find any published RCT studies on group debriefing (Mayou et al. 2000).

Psychological Trauma in the Workplace

Critical incidents are events that occur everywhere; workplaces are not immune. Particular occupations have an increased risk of work-related violence due to the very nature of their job. Only in the last twenty years has research looked into the idea that emergency workers (or people in the helping professions) could be secondary victims of trauma (Moran, 1998; Watts, 1994). High risk occupations deal with serious events that can bring with them a lot of responsibilities in a short period of time; empathy with victims, high distress levels and upsetting images on a semi-regular basis.

A worker's chances of developing PTSD are increased in high-risk occupations (Mitchell & Everly, 1995a). These occupations include the police, fire service, emergency medical personnel, disaster workers, mental health providers and the military (Mitchell & Everly, 1995b; Williams, T., 1993). Mental hospital staff (Flannery et al., 1991) and nurses (Matthews, 1998) face assaults in their jobs and are at risk of developing symptoms of post-traumatic stress.

Therapists (Shalev et al., 1993) and psychologists, occupations not usually thought of as high-risk, are vulnerable to vicarious traumatisation. This is when people are traumatised by, or through, other people's experience of a critical incident (Figley & Kleber, 1995). Talbot et al. (1995) believe psychologists may have post-traumatic stress symptoms that are unique to their profession. They say this is due to the issues psychologists' face, such as, the role they play in crisis work, their emotional response to the victim and the expectations by the organisations of the psychologist.

One of the main findings that have come out of trauma literature is that all people can be affected by critical incidents, which means emergency personnel are also vulnerable

(Mitchell, 1983). As Robinson (1995) points out, trained and experienced workers can succumb to the effects of a critical incident. Many professionals in the helping professions struggle with this fact. Instead, many feel they should be able to handle work-related incidents (Matthew, 1998).

Organisations also need to remember that other people besides the emergency personnel directly involved can be affected by an incident. The colleagues of those directly involved also bear the brunt of the trauma, even though they may not have been around at the time of the incident (Figley & Kleber, 1995). Other professions not often thought to be affected by incidents include; reception staff, radio and telephone operators, administrators, volunteer workers, delivery staff and bystanders (Deahl, 2000; Mayhew, 1997; Williams, T., 1993).

In looking for a rationale for providing work place stress prevention programmes, organisations need look no further than at the health of their employees. A vast array of research has been conducted on the deleterious effects critical incidents have on people. These effects include; sick leave, early retirement, low morale, withdrawal, working below capacity, disruptive behaviour, increased tension and work load amongst other employees (Figley & Kleber, 1995), workplace arguments, task avoidance and mood changes (Hutt Valley Health, 1999).

Berah et al. (1984) found a volunteer mental health team's emotional and physical health was compromised after working at a disaster site. Mitchell and Dyregrov (1993) reported signs of stress in emergency workers included; absenteeism, job turnover, decreased job satisfaction and mistakes in the job performance. High-risk professions (Mitchell & Everly, 1995a) and staff in direct care settings (Matthews, 1998) are at risk of developing symptoms of post-traumatic stress or the further development of PTSD. Personal costs can include; relationship problems, substance abuse, depression and anxiety, which in turn can become the hidden costs of an organisation (Robinson, 1995).

According to Hutt Valley Health (1999), a large part of occupational stress is its accumulation over time. Exposure to critical incidents by those in high-risk occupations is often repetitive and cumulative (Figley & Kleber, 1995), which may lead to burnout, detachment and not being able to cope with future critical incidents (Raphael et al.,

1996; Shalev, 1994). All of these symptoms of stress are good reasons for organisations to invest money in providing workers with the support they need. The perceived benefits of debriefing involve helping to reduce any psychological distress related to critical incidents (especially the symptoms of PTSD), reducing workers' anxieties about exhibiting stress reactions and needing some help (Parkinson, 1993) and educating workers about stress to help increase their return to normal functioning.

As research has shown, employees who work in high-stress jobs are at an increased risk of developing stress-related illnesses. The development of depression or PTSD for example, can require lengthy treatment programmes, which are expensive to maintain (Canterbury & Yule, 1999). It seems to make much more sense to invest money in helping prevent stress-related illnesses than trying to treat them. Debriefing programmes may be able to provide a much-needed preventive intervention organisations are looking for.

Mitchell and Everly (1995a) point out that employee claims for work-related stress was one of the most expensive and fastest developing insurance claims affecting business in the United States. According to Green (1997), ten percent of the United Kingdom population experience a form of mental illness over a one year period, which results in 3.7 billion pounds lost per year in working days alone. There is a need for something to be done to prevent or at least lessen work-related stress. Since there are many high-risk occupations that exist, organisations are finally recognising the need to put in place clear and specific policy guidelines on how to minimise the impact of work-related stress on employees and organisations (Deahl, 2000). In workplaces where there is a high incidence of critical incidents creating a need to get employees back to good health, debriefing programmes could provide the answer organisations are looking for (Mitchell, M., 1999).

It should be pointed out that an organisation does not just have a financial incentive to provide preventive interventions. They also have a duty to their employees to provide for them a safe and supportive work environment, and to help look after their health, especially those in high-risk occupations (Deahl, 2000). Organisations that set up critical incident policies and programmes are demonstrating to their employees that they care about their well-being.

Te Whare Ahuru

Te Whare Ahuru was set up in 1997 and is the mental health inpatient unit at Hutt Hospital. The unit comprises open and locked facilities, and an acute day service programme for outpatients. Te Whare Ahuru can have a maximum of 26 inpatients, including 5 spaces for acute patients. The acute day service averages between 14 and 20 outpatients per day.

The staff of Te Whare Ahuru consists of 32 fulltime equivalent nurses, which includes the clinical nurse manager and co-ordinator of the ward. The nurses are both enrolled and registered nurses. The staff also includes a rotating number of full and part time house surgeons (1), social workers (1), occupational therapists (1-2), psychiatrists (2), and psychiatric registrars (1-2). Te Whare Ahuru also has two administrative staff. The perceived job turnover at Te Whare Ahuru is about 30% according to staff. All of the graduate nurses and about one quarter of the rest of the staff at Te Whare Ahuru receive supervision.

Debriefing started at Te Whare Ahuru in 1998. The programme is based on the Mitchell model of debriefing and is adapted here for work with groups and individuals. It was implemented across all mental health services, not just in Te Whare Ahuru. However, Te Whare Ahuru was the main focus of the programme, as the majority of the critical incidents were occurring there. The debriefing programme also includes the three community bases and the general wards of Hutt Hospital. The programme was introduced as a way to support staff experiencing critical incidents in the workplace. It was thought that the introduction of debriefing might result in improved staff morale, a decrease in sick leave, improved staff retention and be of psychological benefit to the staff.

All the staff were asked if they were interested in volunteering to be one of the debriefers. The debriefing team are a multidisciplinary group of people, who all have a background in mental health. The team has had anywhere between 6 and 13 members over the last few years. General hospital staff had also been encouraged to join the team. At the time the data was collected for the present study four of the original team from 1998 remain on the debriefing team now. Two members of the debriefing team

run each debriefing. The debriefing team meet roughly every month to, review any debriefings that have occurred, discuss any on-going training or peer revision and sort out any administration issues. However, the staff that make up the debriefing team have changed from when it originated in 1998.

The debriefing team have only received two training sessions since the debriefing programme's inception. People outside of the service trained them. The first training course was half a day long, and conducted in 1998 by two people from forensic services, who were involved with debriefing the police and the fire service. The second training course was in 2001, and taken by a clinical psychologist from Australia who specialised in debriefing. It was a four-day course and more comprehensive than the first course.

The debriefing team are given a folder (Appendix A) explaining the debriefing process and protocol. It also contains the debriefing team's code of ethics, a follow-up questionnaire, and the debriefing policy. This folder is also to be made available in the nurses' station, on the ward at Te Whare Ahuru, for the staff to have easy access if they want to find out about the debriefing programme. Nurse graduates are usually informed about the debriefing programme when they start work at Te Whare Ahuru and are referred to the debriefing policy. The folder was put together in 1999 by the debriefing team, with material borrowed from Christchurch's mental health service.

The results of the staff feedback forms evaluating debriefing are discussed at the debriefing teams' monthly meeting. These forms are destroyed after each meeting to ensure confidentiality. So far, the results have been positive and most staff have found the debriefings helpful. One person commented that their debriefing was held too long after the incident had occurred. The debriefing team found that when a stamped, self-addressed envelope was provided, the response rate increased.

Te Whare Ahuru staff receive their debriefings from people outside of their immediate circle, who are from one of the three community outpatient bases, affiliated with Te Whare Ahuru. Staff usually had to ask for a debriefing except when very serious critical incidents occur, then one is arranged for staff. Staff can either contact their supervisor, the nurse manager, or the co-ordinator of the debriefing team. Debriefings

ideally occur within a 72 hour period after the incident. Debriefings are a single session and are usually group orientated (being aware that some critical incidents may only involve two or three staff members), with an average of five or six people per debriefing. Individual debriefings use the same structure as a group one.

A debriefing is voluntary and usually takes an hour, to an hour and a half to complete, and staff are encouraged to attend. If a person is really distressed in the debriefing, they are usually approached at the end of it and offered someone to talk to, time out or an Employee Assistance Leaflet. The EAP leaflet is for staff that may want outside support or counselling provided by an outside contractor. It is anonymous and up to three sessions are paid for by Hutt Valley Health. Debriefings are supposed to be held in a place close to the venue of the incident, so it is easily accessible for the staff involved. A follow-up is offered to those attending a debriefing in the form of another debriefing, or if a person wants individual therapy, they are referred to the EAP leaflet.

During a debriefing a booklet prepared by Te Whare Ahuru (Appendix B) is handed to those attending. The CISM programme is designed "to minimise adverse psychological reactions" (p. 2, Hutt Valley Health, 2001), and the debriefing team are "designed to support Hutt Valley Health Staff, in dealing with traumatic incidents" (p. 2, Hutt Valley Health, 2001). These are important distinctions. It provides information on what critical incidents and debriefings are, symptoms of stress, support strategies for staff and their families, information on Employee Assistance Programme (EAP), and helpful references on coping with stress.

Two facets of the CISM programme are defusing and peer support. Team leaders offer defusing at Te Whare Ahuru, at the time a critical incident occurs, but before the staff shift is over, to make sure staff are okay and have support. Peer support is received in the form of supervision. This happens regularly within occupational groups, such as social workers and psychiatric nurses. There is also some informal peer support amongst staff at Te Whare Ahuru.

Hutt Valley Health has two critical incident policies; one is the company policy written by risk management (Appendix C), the other is the mental health services policy written by a group called in to standardise Hutt Valley Health policies (Appendix D). The

original policy said Hutt Valley Health mental health services would provide 24-hour access to peer support, and a folder for (and about) the debriefing team, to each area of the service, with an updated list of debriefers. The company and mental health services policies were updated at the end of 2000 to supersede the original policy set up in 1998. The company policy addresses CISM and is to "provide a process to support staff involved in an incident and to reduce recovery time from a stressful experience by restoring staff to normal functional efficiency" (p. 1, Hutt Valley Health, Oct, 2000). The mental health services policy states it provides "a professional service that supports and minimises stress for Hutt Valley District Health Board staff involved in a critical incident related to Hutt Valley District Health Board operations" (p. 1, Hutt Valley Health, Dec, 2000). This policy also adds it has a responsibility to any non- Hutt Valley Health District Health Board staff involved in or affected by a critical incident to provide debriefings if required.

Both policies state managers should ensure staff have had the chance to talk after an incident and check they will be safe and supported. They also stipulate debriefings can be individual or group meetings, and should be no longer than seven days after an incident, in an easily accessible venue, removed from the work setting. The company policy says an operational debriefing should be conducted, with recommendations for changes to procedure needing to be followed up. The mental health services policy has a few differences to the company policy. Hutt Valley District Health Board staff are to be told of debriefing procedures if they are involved in an incident. Approved debriefing facilitators must run formal debriefings, and any non-Hutt Valley District Health Board staff involved in or affected by a critical incident are to have access to debriefings if they need it. An independent trainer will train the debriefing team and they should receive supervision and on-going training throughout the year. Finally, the progress of debriefings and the debriefing team will be examined.

No evaluations of the debriefing programme have occurred since its inception, except for feedback from the forms on the back of the debriefing folder.

The Importance of Evaluation

There is a need to evaluate debriefing programmes (and models) especially because of the contentious nature of the debate on debriefing's effectiveness. Evaluation into debriefing has only been prevalent over the last ten years, and the evaluation literature has tended to focus on select groups, such as disaster and rescue workers, the police force, and fire service personnel. Most of the literature evaluates individual debriefings, with no research into group debriefing (Mayou et al., 2000; Rose & Bisson, 1998).

The popularity and use of debriefing has been partially fuelled by its perceived efficacy, thanks to numerous anecdotal evaluations (Deahl, 2000; Everly et al., 1999). Debriefing has come into practice without first establishing a strong research base to establish its efficacy (Bisson & Jenkins, 1997). The need to 'do something' and provide help to vulnerable people seems to have superseded the evaluation of these preventive interventions believe Raphael et al. (1996).

Another reason for the development of debriefing and lack of evaluation revolves around the role of organisations. Moran (1998) suggests the increase in work-related stress litigation cases has meant organisations need to be providing help and support to their employees; one form of this is in debriefing. However, this urgency to put debriefing in place does not seem to have conveyed to the evaluation of its effectiveness. Yamey (2000) puts forward the idea that debriefings are a quick response to put in place for organisations, as most models are structured and organised.

Obviously, evaluation needs to be conducted to find out if a debriefing programme is effective, if it does what it purports to do and if people like it. It's important to examine whether the programme is improving a person's short term and/or long term psychological functioning (Raphael et al., 1996; Shalev, 1994). Consistent and on-going evaluation provides up to date knowledge for everyone on the status of debriefing's efficacy.

It is not enough to say a programme works or doesn't work. The questions of how it works and why it works, are just as crucial. Organisations need to know what parts of the programme are most beneficial to participants, and which model is the most

successful. Only a small amount of research has taken place into the crucial features of a successful intervention, according to Raphael et al. (1996).

Organisations can use evaluations to determine how cost-effective a debriefing programme is for them, but many do not (Green, 1997). It would be useful for comparisons to be made between employees with high sick leave, absenteeism and stress levels, and those who attended a debriefing. An evaluation can also determine management's accountability to a programme's success or failure. Providing feedback to an organisation is important as it allow them an opportunity to improve their programmeEven though research needs to be conducted on psychological debriefing, it is not necessarily easy to conduct. Some professions are reluctant to provide help when research is being conducted (Robinson & Mitchell, 1993). There are so many facets to undertaking an evaluation of debriefing, but the most crucial one is that an evaluation is conducted in the first place.

As McKenzie and Smeltzer (2001) explain, evaluation is the way effective programmes are found, created or improved upon, and the way to show organisations the cost-effectiveness (or lack of), of their programme. They go on to introduce the idea that there are different types of evaluations that can be conducted, depending on what is trying to be achieved. Evaluation can be about making changes before or during the implementation of a programme, finding out if a programme is successful, or investigating if the programme's goals have been achieved. However, evaluation is only beneficial when it has clear aims, is well planned and implemented correctly.

One set of terms Mckenzie and Smeltzer (2001) refer to that define evaluation, are process, impact and outcome. Process evaluation reflects whether problems may lie in the design and/or implementation of a programme. In other words, why it was or wasn't successful. These problems could be before or during the programme's use. Examples of issues that process evaluation addresses are, whether the timing of the programme was appropriate, when and how it was offered, who it was offered to and whether it was implemented correctly. Impact evaluation is the noticeable changes that have taken place, such as changes in awareness, skills or behaviour, which can lead in to the proposed outcomes the programme predicted (McKenzie & Smeltzer).

Outcome evaluation is usually what most people associate with evaluation, as it investigates whether a programme achieved its goals. It can be measured in a variety of ways, depending on the need of the evaluation. For example, success can be gauged by population changes, physical or financial changes, environment, physiological factors, health indicators and attendance or use of a programme. Bartholomew, Parcel, Kok, & Gottlieb (2001) present process evaluation as focusing on those who received the intervention, whilst the impact and outcome evaluations look at the differences between groups' outcomes due to the intervention.

Rationale for the Present Study

Formal evaluation of the debriefing programme at Te Whare Ahuru has not been conducted since its inception in 1998. The organisation was unsure as to the programme's efficacy in helping staff deal with, and recover from, critical incidents. The organisation did not know if the goals of the debriefing model were being achieved. There was also no information about what the staff at Te Whare Ahuru knew about the programme, or how they felt about it. The purpose of the present study is an attempt to address these issues in a baseline, cross sectional study of the implementation and effectiveness of the debriefing programme at Te Whare Ahuru. It was also hoped the information that was gathered would provide useful feedback to the debriefing team at Te Whare Ahuru, to help with the programme's development and provide a better understanding of how the programme works. Accordingly, in this study the evaluation of process, impact and outcome was used to evaluate the debriefing programme at Te Whare Ahuru. The present study aims to answer the following research questions:

Did staff at Te Whare Ahuru get a debriefing when it was appropriate?
What do the staff at Te Whare Ahuru know about the debriefing programme?
How do the staff at Te Whare Ahuru feel about the debriefing programme?

What were the staff's experience of the debriefing programme at Te Whare Ahuru?

Was there any relationship between a staff member's debriefing status, and their attitude to, and knowledge of, debriefing?
Was there any relationship between a staff member's debriefing status and their psychological and physical health, and job satisfaction?
Was there any relationship between the staff's attitude to, knowledge of, and experience of debriefing and their psychological and physical health, and job satisfaction?

METHOD

Research Setting

To conduct research on the debriefing programme at Te Whare Ahuru, the participants were drawn from staff who currently worked at or had recently left Te Whare Ahuru, as that was where the debriefing programme was provided. A clinical psychologist form the debriefing team told staff at their handover shift meetings of the present study, and encouraged them to fill out a questionnaire. The staff are predominantly nurses, but a range of other mental health professions are also represented.

Participants

Fifty questionnaires were handed out, and 18 staff completed and returned them over a period of one month, leaving a response rate of 36%. Thirteen staff members had received a debriefing at Te Whare Ahuru and five had not. More females (72.2%) than males (22.2%) responded to the questionnaire. This uneven gender split reflects the tendency for mental health professionals to be female, especially in the fields of nursing and social work. One person did not indicate their gender.

Participants ranged in age from 23 to 65 years (M = 39.5, SD = 10.96). Half of the participants were aged 36 years or younger at the time of this study. The majority of participants (66.6%) described their ethnicity as New Zealand European. One person described themselves as a Pacific Islander, whilst five people identified themselves as either British, European or American. The uneven split between groups was unexpected. No people in the present study identified themselves as a New Zealand Maori.

The average amount of sick leave taken in the last six months by Te Whare Ahuru was 1-7 days, with one person taking more than 21 days. Length of service in the mental health field was split evenly, with nine people having worked between 1-10 years, and nine having worked between 10-20 years. This was to be expected with the age range

of participants split into similar proportions, as age is usually indicative of length of service in an organisation.

Table 1

Demographic Characteristics at Te Whare Ahuru

Characteristics	*n*
Gender	
Male	4
Female	13
Unknown	1
Ethnicity	
New Zealand European	12
New Zealand Maori	0
Pacific Islander	1
Other	5
Age When Survey Completed	
20 – 29 years	3
30 – 39 years	6
40 – 49 years	7
50 – 59 years	1
60 or older	1
Sick leave taken in the last six months	
0 days	2
1 – 7 days	11
7 – 14 days	4
14 – 21 days	0
More than 21 days	1
Length of service in mental health field	
1 – 5 years	4
5 – 10 years	5
10 – 20 years	4
More than 20 years	5

Note. Maximum N = 18

It is not known whether the characteristics of those who chose to respond to the questionnaire are any different from those who chose not to respond. Therefore, caution is advised in generalising the findings in the present study.

Measures

A questionnaire was used to conduct a thorough baseline evaluation of the debriefing programme at Te Whare Ahuru. Participants in the present study completed a nine-page questionnaire comprised of seven measures and demographic questions (Appendix E). The first two measures addressed process evaluation and the third dealt with impact evaluation and were all designed specifically for this study. Two measures were used to look at psychological health, the IES-R assessed post-traumatic stress symptoms, and the HSCL-21 assessed general psychological health. The self-rated health scale was used to measure physical health. The overall job satisfaction measure assessed the participants opinions of various features of their job. The last measure was made up of demographic questions. These were included for correlation and assessment purposes and to investigate their relevance in understanding the outcome measures.

Brevity was an issue in the choice of measures to be used as the question was made up of several measures and if they were too long participants were less likely to respond. According to McFarlane (1995b) questionnaires can be a helpful screening tool for identifying people at risk or those who would benefit from intervention. Questionnaires are also useful to monitor peoples responses over time. Many researchers have used questionnaires to evaluate debriefing (Berah, Jones, & Valent, 1984; Jones, 1985; Kent & Kunkler, 1992; Robinson & Mitchell, 1993; Solomon & Benbenishty, 1986; Turner et al., 1993).

Derogatis, Lipman, Rickels, Uhlenhuth and Covi (1974) believed the advantage of self-report scales being able to acquire thoughts and feelings that are not accessible to observers. Observers are limited to reporting what they see and hear from participants. Self-reports are also economical in time and can complement clinical interviews (Derogatis et al.). Self-reports are important because they provide first hand knowledge about the effect of an incident or programme on a participant.

Critical incidents and Debriefing at Te Whare Ahuru

The first measure contained nine questions addressing the nature and frequency of critical incidences and debriefing at Te Whare Ahuru. Participants were asked to provide descriptive information on their most recent incident, how long ago it was and the amount of incidents and debriefings staff had been involved with at Te Whare Ahuru. Most of the questions were related to the incident staff stated was the most recent at Te Whare Ahuru. Eight of the nine questions were open-ended in nature. Information from these questions was grouped into categories for descriptive purposes. The last question on the scale deals with how staff received their information about the debriefing programme

Knowledge of the Debriefing Programme

To evaluate the level of knowledge staff at Te Whare Ahuru had about the debriefing programme, a measure was constructed for the present study. Knowledge was considered to be an important determinant in the process of a programme. The knowledge measure in the present study was used to assess awareness of issues. As the present study is a baseline study it was also important to collect information on this issue for the purposes of future comparisons. The measure consisted of four items rated on a five point likert scale with 1 representing 'very true for me', a 3 indicating 'I don't know' and a 5 representing 'very untrue for me'. Three of the items related to the general set up of a debriefing at Te Whare Ahuru and one item referred to support after a debriefing. A high score on this measure represents a good level of knowledge about the debriefing programme at Te Whare Ahuru. The knowledge measure had strong internal reliability with an alpha coefficient of .80.

Attitudes Toward Debriefing

A measure to assess attitude towards debriefing needed to be developed for the present study. Attitudes were considered to be important to evaluate because they may determine the attendance at a debriefing and provide information on the process of the debriefing programme. The measure is made up of four items each representing a different facet of the debriefing programme. Responses were chosen from the same five point likert scale used to evaluate knowledge. A higher score on this measure indicated a positive attitude toward debriefing. However the attitude measure proved to have no

internal reliability with an alpha coefficient of -.11. It was decided to use one item 'I would rather deal with the emotions I experience from a critical incident, on my own, and not in a debriefing session' to assess the attitudes of staff at Te Whare Ahuru.

Experience of debriefing

For the purposes of the present study a measure was created to evaluate participants experiences of the debriefing programme at Te Whare Ahuru. This measure was included in the present study because the current evaluative literature states most people viewed debriefing quite positively, regardless of their score of other outcome measures. The information from this measure was used to detect what participants experience of debriefing was, and the reasons for this.

Care was taken in selecting the items when putting the measure together. Questions were evenly split into positively and negatively toned statements (seven items of each). Where possible, simplified language was used and questions were kept to a brief length. Participants were asked to answer this measure if they had attended a debriefing. Responses to each item were on a five point likert scale, with a 1 representing "strongly agree" a 3 signified "I don't know" and a 5 representing "strongly disagree". A likert scale was used to elicit the strength of a response. A high score on this measure indicated a positive experience of debriefing. Closed ended questions were chosen because the answers were easily coded and helped to keep the measure brief. The choice of items that made up this measure were based on some of the contentious issues in the evaluative literature on debriefing namely the process and impact of a programme. Questions were also based on issues that were related to Te Whare Ahuru at the time of the construction of this measure. The experience of debriefing measure displayed strong internal consistency at .82.

Impact Events Scale- Revised (IES-R)

For the purposes of this study the IES-R (Weiss and Marmer, 1997) was used to investigate the presence of post-traumatic stress symptoms after critical incidence, in the staff at Te Whare Ahuru.

The IES-R is based on the IES (Horowitz, Wilmer and Alvarez, 1979), which is a 15 item self-report scale that measures the life events of the past seven days. It represents two of the most commonly reported types of experience after a traumatic event; intrusive symptoms (nightmares, reliving experiences, intrusive thoughts and feelings) and avoidance symptoms (emotional numbing, denial of consequences, avoiding people or places). The scale can provide subscales and a total score to measure the subjective stress. The IES can be used as an assessment over time. To compare different groups subjective distress or compare distress levels across different life events.

The mean total score for the IES was 39.5 (*SD*= 17.2). The mean for intrusive items was 21.4 (*SD* = 9.6) and avoidance 18.2 (*SD*=10.8). Internal consistency of the subscales by Cronbachs alpha was high, so were the test-retest with a split half reliability of total scale (r = 0.86) (Horowitz et al., 1979). Briere and Elliot (1998) investigated the clinical utility of the IES. They found the IES correlated well with other measures of trauma related distress and could be applied to a diverse range of people.

The IES is a very popular measure and has been used by many authors on a range of populations for a range of traumatic events (Kent and Kunkler, 1992; Bisson et al., 1997; Lee et al., 1996). According to Wessely et al. (1999) the IES is the main continuous measure in recent research into debriefing.

However, one of the criticisms of the IES was its lack of items representing the whole experience of trauma. Weiss and Marmar (1997) then developed a revised 22 item IES scale (IES-R) with a new subscale to tap hyperarousal symptoms and an extra item was added to the intrusion subscale. The instructions on the measure are now phrased to assess the degree of distress, not the frequency of the symptoms. The scoring of responses from 0, 1, 3, 5 to 0 - 4 have been changed for simplicity and to help bring the IES-R closer in format to the symptom checklist 90-revised (SCL-90-R). An attractive feature of the new scoring system was being able to compare symptom distress across two popular measures. One other change was to the wording of one item. The intrusive and avoidance scales are otherwise the same as in the original IES.

Two different samples were used to assess the psychometric properties of the IES-R. The first group were emergency personnel with internal consistency co-efficients at baseline of .87 for intrusive, .85 for avoidance, and .79 for hyperarousal. The second group were insurance company workers with internal consistency co-efficients of .91 for intrusive, .84 for avoidance, and .90 for hyperarousal. Both groups had moderate to excellent test-retest reliability. Finally it should be noted that unlike Horowitz et al. the samples using the IES-R were not a clinical sample seeking treatment for diagnosed PTSD.

The measure includes seven intrusion items, eight avoidance items and seven hyperarousal items. Each item is scored of a four-point scale indicating how distressing each item on the scale had been during the last seven days.

Hopkins Symptom Checklist-21

The Hopkins Symptom Checklist-21 is a self-report measure and was devised by Green, Walkey, McCormick and Taylor (1988). It is a 21-item version of the widely used 58 item Hopkins Symptom Checklist (Derogatis et al., 1974). The original Hopkins Symptom Checklist was based on a five factor structure. The measure asked respondents to rate how they had been feeling during the last seven days on a four point likert scale, with 1 representing "not at all distressed" and four representing :extremely distressed". The measure has well-established reliability and validity (Derogatis et al., 1974).

However the five factor structure of the original Hopkins Symptom Checklist was considered to be weak so Green et al. (1988) produced a shorter, simpler version with a stronger factor structure. Green et al. found the Hopkins Symptom Checklist had a discrete replicable three factor structure which produced three subscales; general feelings of distress, somatic distress and performance distress. Each subscale had seven items each. These subscales can be summed to obtain a total distress score. The Hopkins Symptom Checklist-21 was tested on clinical patients form the United States of America and female nurses and university students from New Zealand. The measure produced strong psychometric properties with a total scale alpha of .90 and corrected split half reliability of .91. The subscales alpha co-efficients ranged from .75 to .86 and

the corrected split half reliabilities were from .80 to .89. These results were very similar to those Derogatis et al. (1974) found on the original Hopkins Symptom checklist.

In the present study total distress scores were used and a change was made to the response scale of the Hopkins Symptom Checklist. Participants were still asked to rate their feelings of distress over the past seven days, however the point value ascribed to these answers was altered from a 1-4 scale to a 0-4 likert scale. A 0 represented "not at all distressing" and a 5 represented "extremely distressing" the new middle value of 2 represented "moderately distressed". These changes were made to make the Hopkins Symptom Checklist-21 similar in format to the Impact of Event Scale-Revised. This change also replicates the response scale on the Symptom Checklist 90 (Derogatis, Rickles & Rock, 1976). The present study had a very strong internal consistency rating of .95.

Deane, Leathem and Spicer (1992) collected normative data from New Zealand and assesses the variability and validity of the Hopkins Symptom Checklist-21 on first time psychotherapy clients. The results showed this measure had high internal reliability and sound concurrent and construct validity.

Carlton (1997) used the Hopkins Symptom Checklist-21 when investigating the impact of attitudes and suicidal thoughts on adolescents intentions to seek professional psychiatric help. Watson and Feld (1996) used the Hopkins Symptom Checklist-21 to investigate stress and burnout in paediatric nurses in a New Zealand hospital. Watson and Feld commented that Hopkins Symptom Checklist-21 was a useful indicator of symptoms present in normal populations too.

Self-Rated Health (SRH)

Participant's self-rated their health at the present time, on a five-item response scale using the alternatives; terrible, poor, average/ok, good or excellent. Self-rated health is a useful health outcome in research because it is brief and easily understood. Idler and Kasl (1991) state that self-rated health has been demonstrated to predict mortality ahead of numerous other assessments of health such as current health behaviour, physical disability and genetic and lifestyle risk factors. Pennebaker (1982) also agrees with this

point and reports that symptom self-report measures do correlate significantly with objective measures of health, such as doctors' assessments and medical records. Self-ratings provide a simple, direct and universally understood way of assessing peoples perceptions of their own health (Idler & Benyamini, 1997). The aspects of general health that are being captured by this rating, have not yet been defined.

One thing is certain though, the scale covers any and all aspects of health that the person wishes it to. In their 1991 study, Idler and Kasl used follow up mortality data on people aged 65 years or older to investigate the reasons why self rated health is such a successful predictor of health outcomes. Self-rated health was the second best predictor of mortality in males and the fifth for females. Elderly people whose perception of their health was poor were statistically up to six times more likely to die than elderly people who perceived their health to be excellent.

Idler and Benyamini (1997) conducted a review of 27 international studies, which used self-rated health as a predictor of mortality in longitudinal studies of representative community samples. They found in 23 of the 27 studies that self-rated health was a reliable and independent predictor of a persons mortality. Thereby providing reliable information on the state of a persons' health. O'Brien Cousins (1997) established test re-test reliability and significant concurrent validity for the self-rated health measure in women aged 70 or older. O'Brien Cousins also suggested that assessment of one's own health may be more accurate that traditional forms of health evaluation. This is because they are broader in scope and take in cultural and environmental factors, peoples belief systems and life experiences. Self-rating of health introduces a vast array of variables to consider when answering such a simple question, which makes its predictive value as a measure of health an impressive feat. Idler and Benyamini make an important point about the phrasing of the self-rated question. Studies have used variations of the 'rate your health at the present time' question that the present study has used. Other variations have included "compare your health to other your age", or "in general/ all in all how would you rate your health". It was thought these semantic differences would affect the predictive value of the self-rated health item. However Idler and Benyamini believed the consistency of the results across all variations of the question demonstrates the robustness of the question

A large body of research has accumulated over the fifteen or so years the self-rated health rating has existed with the majority supporting its value as a subjective measure of health. The other main finding across studies is that those people who superficially rate themselves as being in poor health have an increased risk of mortality (Greiner, Snowden, & Greiner, 1999). Self-rated health ratings of good, fair and poor were significantly related to a two-fold increase in risk of mortality

Jylha, Gurdnik, Ferrucci, Jokela and Heikkinen (1998) investigated whether self-rated health was comparable across cultures and genders. Samples were taken from Finland and Italy, of people 65 to 80 years of age. The results suggest self-rated health was a useful measure of health, which correlated with other measures of physical health and may predict mortality more successfully in men than women.

Two separate studies looked at gender influence on self-rated health. Interestingly the study addressing men (Jylha, Leskinen, Alanen, Leskinen, & Heikkinen, 1986) and women (Shadbolt, 1997) both found differences in the association of self-rated health and physical health that appeared to be related to age. Either, self-rated health was rated higher in younger the person was, or the associations between self-rated health and physical health became stronger as people got older.

Overall Job Satisfaction

The overall job satisfaction measure is a 15 item self-report measure created by Warr, Cook and Wall (1979) to fit the need for a robust, brief and simple measure to assess psychological well-being at work. The measure obtains ratings of different features of a job then responses are summed together to form an overall job satisfaction score (Warr et al., 1979). Participants are asked to indicate on a seven point likert scale to rate their satisfaction or dissatisfaction with each of the 15 job features. Total scores may range from 55-105, with a higher score representing a higher overall job satisfaction. However, in the present study the measure was adapted to a five point likert scale. This was to make the measure more consistent with the five point likert scales used in the IES-R and the HSCL-21. A rating of one now signifies extremely dissatisfied and a rating of five signifies extremely satisfied. The total score may range between 15 and 75. The mean for the total job satisfaction measure in the present study was .90.

The measure was made up of intrinsic (7 items) and extrinsic (8 items) job features. Warr et al (1979) defined intrinsic features as the ideas of personal achievement and task success whilst extrinsic features were more to do with the job itself such as working conditions and pay rate. Warr et al. state that the choice of whether or not to use the total scale or the subscale depends on the precision a study is requiring. In the present study an overall measure of job satisfaction was all that was required. This was to complement the other measures and provide another variable to assess the effects of stress related to critical incidences.

To test the measure's psychometric properties, interviews were conducted with a sample of 200 and 390 blue-collar male workers from the United Kingdom. The results of the first study of 200 workers were used to refine the measure and the second study was used to produce reliability and validity norms. The mean for the total job satisfaction measure (on a seven item likert scale) for study one was 69.86 (*SD* 14.18) and 70.86 *SD*16.02) for the second study. Internal reliability for the total job satisfaction scale of .85 was recorded for the first study and .88 for the second study. The subscales were found to be factorially discrete. The sub scales of extrinsic and intrinsic job features were correlated at .72 test-retest reliability was assessed using 60 of the participants from the second study. They were re-interviewed six months after the original interview. The job satisfaction correlation co-efficient was .63.

Clegg and Wall (1981) investigated the generalisability of this measure across other organisation specific jobs. They also collected psychometric data so comparisons of this measure could begin. The sample of 659 compared managers, supervisors, white collar, and blue-collar workers from an engineering factory in England. The mean and standard deviation for job satisfaction measure were very similar to the original sample, but the internal reliability was higher .92 for the total scale. The measure showed good reliability, was factoraly distinct and had reasonable construct. A New Zealand study by Alpass, Long, Chamberlain, and McDonald (1997) used this measure to assess job satisfaction differences between military and non-military personnel.

Procedure

Hutt Valley Health's Mental Health Services requested that research be conducted on the debriefing programme at Te Whare Ahuru. A meeting with representatives from Te Whare Ahuru and the debriefing team ensured there would be a commitment to the research on the part of the organisation. A research proposal detailing the rationale and aims of the present study was sent to the Te Whare Ahuru Service Manager for approval. A proposal was then sent to the Massey and Wellington Ethics Committees and the Hutt Valley Health District Health Board Ethics Committee.

A clinical psychologist conducted talks at two staff handover shift meetings, two weeks before the questionnaires were handed out to ensure all the staff were informed of the present study, and were given information sheets. Two weeks later the researcher introduced herself and the present study to some of the staff of Te Whare Ahuru at a staff handover shift meeting. This was considered to be the best time to make contact with the staff, as they were available and had the opportunity to ask any questions. Questionnaires with an information sheet (Appendix F), an EAP leaflet (Appendix G) and a stamped, self-addressed envelope (to maximise responses) were given to staff interested in participating in the study. The introduction by the researcher/author at the shift meeting was then repeated the next day at another shift meeting.

Staff were given the option of completing the questionnaire after the meeting, but were under no pressure to do so, which was why a self-addressed envelope was provided with the questionnaire. Staff who were absent from the handover shift meetings had a cover letter informing them about the present study (Appendix H), questionnaire, information sheet, EAP leaflet, and a stamped self addressed envelope sent to them at this time through the organisations internal mail. Approximately two thirds of the questionnaires were handed out in this way. The questionnaire took about fifteen minutes to complete. Participants were informed that the return of the questionnaire implied informed consent. A total of 50 questionnaires were either handed out or sent through the Te Whare Ahuru internal mail. A sealed box was left in the nurses station on the ward at Te Whare Ahuru for staff to return their completed questionnaires if they wished to complete the questionnaire at Te Whare Ahuru. The researcher came back and collected the box one week later. A reminder letter (Appendix I) thanking participants,

and a further 50 questionnaires were distributed to all the staff at Te Whare Ahuru via the internal mail system, two weeks after the initial questionnaires were first handed out. This was an attempt to improve the response rate. The response rate increased, with a further two questionnaires being received. Completed questionnaires were assigned a respondents identification number by the researcher, as they were received in the mail at Massey University. A total of 18 completed questionnaires were obtained for the present study.

Ethical Issues

Ethical approval for the present study was obtained from the Massey University Human Ethics Committee. Approval was also obtained from the Wellington Ethics Committee and the Hutt Valley Health District Health Board, with support from the Mental Health Services Manager.

The main ethical issues to be considered were informed consent, confidentiality and potential harm to participants. To ensure that the participants understood their rights, information sheets were provided to all participants, thus, avoiding participant deception. The information sheets outlined the purpose and method of the study, confidentiality issues, rights to withdraw from the study, what the information would be use for, and where a summary of finding would be available. This allowed participants to choose whether they wished to take part in the study. Participation was voluntary and no remuneration was provided to participate in the study.

Confidentiality was guaranteed at all times. This was ensured by delivering the questionnaires, information sheets and EAP leaftlets and envelopes with no identification marks, and providing an unmarked stamped, self addressed envelope to Massey University, for the return of the questionnaires. As they were received, each questionnaire was then labelled with a number code for data analysis purposes, thus assuring participants anonymity. The data was kept securely. The questionnaires were not given to the organisation, nor was any other data relating to the questionnaires, except for the summary of the results. If Te Whare Ahuru wanted to conduct longitudinal research into their debriefing programme, it was agreed the anonymous

questionnaires would be handed to the clinical psychologist who initially proposed the research. Only the clinical psychologist, the researcher and the researcher's supervisor, would have access to the questionnaires. Participants were informed of this on the information sheets. However, the clinical psychologist no longer works at Te Whare Ahuru or Hutt Valley Health.

The questionnaire is not intended to be threatening or upsetting to participants. However, in the event that this should happen, participants' were given a copy of the Hutt Valley Health EAP leaflet with the questionnaire. Participants were also given a telephone number to contact the researcher if they had concerns or questions relating to the present study. The researcher was not contacted by any of the participants.

RESULTS

Preliminary Data Analysis

The response rate to the questionnaire was low. Of the 50 people who were sent the questionnaire, only 36% of the staff affiliated with Te Whare Ahuru, returned it. The small sample size was very influential on the choice of statistical analyses that would be conducted on the data.

Prior to commencing the main analyses, the data was screened to check for data entry errors, missing values and the distribution of the variables. The attitude, knowledge and evaluation of debriefing scales were reverse scored (re-coded) so the positive responses received higher scores and negative responses received lower scores. Six participants had missing values that were randomly placed through the data; these were replaced with the mean for each item. However, Tabachnick and Fidell (1996) believe missing values that are found randomly through a data set rarely cause serious problems in statistical analyses

Examination of the data identified a multivariate outlier, with extreme scores on more than two scales. As most scales had varying degrees of skewness and/or kurtosis, data transformations were performed to try to minimise the impact of the outlier, and rectify failures of normality. Square root and logarithmic transformations did not result in much change to the findings. The multivariate outlier was still present.

The author looked at the benefits of retaining or deleting the multivariate outlier, and decided to retain this participant for two reasons. Firstly, the participant's descriptive results were very interesting and highlighted some important issues. Secondly, the sample size was already small, and the statistical analyses would become even less meaningful if a participant was deleted. Also, even without the outlier, there were still some non-normal variables and lack of variability present in the data set. In making this decision, the author acknowledges the lack of generalisability relating to the inferential statistics in this study.

Univariate and bivariate data analyses were used to interpret the raw data. Pearson's product moment correlations were used to establish if any relationships exist between variables, and independent samples t-tests, to compare the means of the debriefed and non-debriefed groups. Two-tailed probabilities were used (as no direction was specified). T-tests and Pearson's 'r' correlations were chosen for their perceived robustness against samples with non-normality. An alpha of 0.05 level of significance was used for all analyses.

Power calculations were considered in the present study but it was recognized the effect size would not be strong, as the population the present particpants were sampled from was small to begin with. There was no option to enlarge the present sample size, as the debriefing programme was only offered in Te Whare Ahuru.

Evaluation of the Debriefing Process

Critical Incidents and Debriefing at Te Whare Ahuru

Participants in the present study were asked to base their responses to the questionnaire on the most recent critical incident they were involved in. Eighteen participants completed the questionnaire; 13 (72.%) had been to a debriefing at Te Whare Ahuru and 5 (28%) had not. The participants had experienced different types of critical incidents and these are listed in Table 2. Five participants were involved in an attempted suicide, four experienced cases that led to the death of the patient (three cases were suicides), three involved in assaults (between patients and on staff), and one participant was part of an armed defenders call out. Two participants had not experienced any critical incidents, and three participants did not describe the critical incident they were involved in.

At the time the questionnaire was filled out, four of the participant's incidents had occurred within the last month, three referred to incidents one to three months previously, four referred to incidents that occurred three to six months previously and five were involved in incidents that occurred more than six months beforehand. Two participants were not involved in any incidents. Therefore, 11 participants who had referred to a specific critical incident, experienced it within the last six months of filling

out the questionnaire. Responses show that three out of the five participants that were not debriefed had been in incidents within three months of filling out the questionnaire.

Nine of the 16 participants that named their most recent critical incident were offered the opportunity to attend a debriefing after that incident occurred, but seven of the participants were not. Therefore, just under half of the participants were not given the opportunity to go to a debriefing. One participant commented that a debriefing was held for their incident, but it was conducted 15 days after the incident. Of the nine participants offered a debriefing, eight attended a debriefing. However, of the seven participants who were not offered a debriefing, six did not attend a debriefing. One participant stated they would have gone if a debriefing had been held for that incident. Two participants chose not to attend a debriefing, stating they were too busy and had no time (one was offered a debriefing, one was not). Participants were then asked if they had received on-going debriefing or other counselling after their critical incidents, three said they had. Two of them were offered and attended a debriefing; the third participant was not offered a debriefing.

The participants were asked to state how many critical incidents they had been involved in at Te Whare Ahuru. As can be seen in Table 2, seven participants were involved in 5 or more critical incidents at Te Whare Ahuru. Those who had been involved in 5 or more incidents made comments such as; they had lost count of the exact number of incidents or the number exceeded 12 incidents.

Table 2 also shows the number of debriefings participants have received at Te Whare Ahuru. Three had not received any debriefings, 11 had attended 1 or 2 debriefings, two had been to 3 or 4 debriefings. Therefore, only 2 of the 18 people had received 3 or more debriefings, when 12 of the 18 people had experienced 3 or more critical incidents. One staff member, who had received 3 or 4 debriefings, had been in at least 12 critical incidents. Three other staff members said they had experienced several incidents, yet all three of them had only received one debriefing each. Of the five people who had never received a debriefing at Te Whare Ahuru, one commented they had been in three incidents, another stated they were involved in approximately 10 incidents and a third person wrote they had lost count of the number of incidents they had been involved in.

Table 2

Type and number of critical incidents experienced at Te Whare Ahuru, and number of debriefings received at Te Whare Ahuru

Type of most recent incident	**No.**
Attempted Suicide	5
Death	4
Assault	3
Armed Defenders Callout	1
No incident described	3
No incident	2

	Frequency	
n	Critical Incidents	Debriefings
0	2	5
1-2	4	11
3-4	5	2
5 or more	7	0

Note. Maximum n value = 18

When asked how they found out about the debriefing programme, four participants stated they did not know about it, eight were informed by their supervisors, three received written information, two found out through their association with the debriefing team and one participant heard about it through word of mouth. The four people, who did not know about the debriefing programme, did not receive any debriefings at Te Whare Ahuru.

Knowledge of the Debriefing Programme

The majority (83%) of the Te Whare Ahuru staff stated they knew what a debriefing session was, one participant said this was untrue for them and two participants responded that they did not know. Two of these last three participants were not debriefed at Te Whare Ahuru.

When asked if they were satisfied with the information they had received about the debriefing programme; eleven participants said they were, five said they weren't, and two said they didn't know. Four of the five participants, who weren't satisfied with the information, were not debriefed at Te Whare Ahuru.

Most (66.6%) of the staff knew how to get a debriefing after a critical incident, three participants said this was very untrue for them and another three did not know. Four of these last six participants were not debriefed at Te Whare Ahuru, and the other two did receive a debriefing, yet they say they were unsure if they knew how to get one.

Eleven participants reported they knew there was someone they could contact if they wanted to talk after a debriefing. However, four participants said this was somewhat or very untrue for them, and three participants said they didn't know. Four of these last seven participants were not debriefed at Te Whare Ahuru.

There was one participant who answered 'I don't know' on all four of the knowledge questions. Yet this participant had received a debriefing at Te Whare Ahuru. Under the previous section, critical incidents and debriefing at Te Whare Ahuru, four participants said they did not know about the debriefing programme. These same four participants have consistently answered poorly on the knowledge measure.

Attitudes Toward the Debriefing Programme

Fourteen of the participants from Te Whare Ahuru stated they did not have to ask for a debriefing for themselves. Three participants have had to ask for a debriefing, and one participant did not know. When asked if they had attended every debriefing session that was offered to them, 13 participants reported this was somewhat or very true, four stated this was somewhat or very untrue, and one participant did not know. Of the 13 participants that reported they had attended every debriefing offered, three actually had

not attended a debriefing but said that they would attend if one were offered. These same three people have never been to a debriefing at Te Whare Ahuru. One hundred percent of the participants who returned the questionnaires, found the idea that debriefing programmes had no place at Te Whare Ahuru to be somewhat or very untrue. When asked if they would rather deal with their emotions from an incident by themselves, instead of in a debriefing, 14 staff disagreed, but, four participants found this statement to be true for them.

Table 3

Descriptive Statistics of the Knowledge, Attitude and Experience of debriefing measures

				Debriefed		Non-Debriefed		
Measure	***n***	***M***	***SD***	***M***	***SD***	***M***	***SD***	**Range of scores**
Knowledge	18	15.11	4.50	17.31	2.75	9.40	2.61	6-20
Attitude	18	4.00	1.19	3.92	1.19	4.20	1.30	2-5
Experience of Debriefing	12	55.82	6.06	55.82	6.06			40-63.81

Evaluation of the Impact of the Debriefing Programme

The responses to the experience of debriefing measure are based on 12 people ($N = 18$), as five participants did not receive a debriefing at Te Whare Ahuru, and one participant who was debriefed chose not to answer this section. The mean total score was 55.81 ($SD = 6.06$) and the scores ranged from 40 - 63.81 (see Table 3). A higher score represents a more favourable experience of the programme.

As can be seen in Table 4, staff were positive about debriefing with 10 participants in this study (83%) stating they felt better after the debriefing. Another positive result was

that 10 participants (83%) indicated they would attend another debriefing. Of the participants who disagreed with some of the positive statements, one participant disagreed with three of the items and stated they did not know if they would choose to attend another debriefing. This person had received one debriefing at Te Whare Ahuru, and their score on this measure indicated a negative opinion of the programme. The other participant who did not know if they would attend another debriefing, had been to two debriefings at Te Whare Ahuru, and had a generally favourable opinion of the debriefing programme.

Table 4

Descriptions of how helpful debriefing was for the staff at Te Whare Ahuru

Agreement with the positive items on the Experience of Debriefing Measure	*n*
Debriefing session made me feel better	10
Attendance at the debriefing was encouraged	12
Debriefing was well run by the debriefing team	11
Debriefers were sympathetic	10
Debriefers helped people feel at ease	11
I would choose to attend another debriefing	10
I believe a professional needs to be available to staff in case they want to talk after a debriefing	11

The aspects of the debriefing that staff in the present study found unhelpful are shown in Table 5. The low number of responses to the negatively framed questions indicates most people found the debriefing to be helpful. The participant who disagreed with some of the positively framed questions, also agreed with four items that were negatively framed. Therefore, the participant had a poor opinion of the debriefing programme at Te Whare Ahuru. Two participants felt their debriefings were provided too soon after the incident. Two participants stated they felt worse after their

debriefings, and one did not know if they felt worse. One participant felt pressured to talk in the debriefing, and three participants did not know if they felt pressured to talk. Only two participants felt uncomfortable expressing themselves in the company of others.

Table 5

Descriptions of how the debriefing was not helpful for the staff at Te Whare Ahuru

Agreement with the negative items on the Experience of Debriefing Measure	*n*
It was a waste of time to attend the debriefing	1
Debriefing was held too soon after the incident	2
Debriefing made me feel uncomfortable	0
I felt worse afterwards	2
I found the debriefers to be intrusive	1
I felt pressured to talk	1
I don't like expressing myself in front of others	2

Relationships between Debriefing Status and the Knowledge, Attitude and Experience of Debriefing Measures

The knowledge measure showed up disparities between a person's debriefing status and their knowledge of the programme at Te Whare Ahuru. A bivariate Pearson's correlation was run between these two variables and the results are displayed in Table 6. There was a strong, statistically significant, inverse correlation between a person's score on the knowledge measure and their debriefing status ($r = -.81$, $p = .000$). This relationship suggests that the more knowledge participants have about the debriefing programme at Te Whare Ahuru, the more likely they were to attend one.

The mean total score for the knowledge measure was 15.11 ($SD = 4.50$) as seen in Table 3. The mean for the debriefed group was much higher ($M = 17.31$, $SD = 2.75$) than the

non-debriefed group ($M = 9.40$, $SD = 2.61$). These means suggested that, in this sample, staff that had greater knowledge of the debriefing programme received a debriefing. An independent samples t-test (two-tailed) for equality of means showed that this difference was statistically significant $t\ (16) = 5.53$, $p = .00$.

No correlations between the attitude measure, the knowledge and experience of debriefing measures, and debriefing status were statistically significant. As can be seen in Table 3, the mean total score for the attitude measure for the non-debriefed group was slightly higher ($M = 4.20$, $SD = 1.30$) than for the debriefed group ($M = 3.92$, $SD = 1.19$). This indicates no difference in attitudes toward debriefing between the groups. An independent samples t-test showed the mean differences between the groups to not be statistically significant $t\ (16) = -.43$, $p = .67$.

The majority of the participants had a positive experience of the debriefing provided for them. The staff with the top four scores on this measure all had equal numbers of critical incidents and debriefings, with the exception of one person, who had three incidents and two debriefings.

The researcher wanted to know if the ten people who had attended every debriefing offered to them, liked the debriefings they had received. Four people received scores on the 'experience of debriefing' measure below the 50% threshold mark of the group's total scores on this measure. The low scores indicate these four participants had some problems with the way the programme was being implemented. Scores of the four participants who stated they preferred to deal with their emotions from an incident on their own, were also examined to see if they liked the debriefing they received (as a debriefing would involve expressing emotions in front of others). One of these participants had not been debriefed. Of the three others, two had low scores on the experience of debriefing measure, and one said they did not know if they would attend a debriefing again.

Table 6 shows that no correlations tests were significant between the experience of debriefing measure and the participant's scores on the attitude or knowledge measures. The relationship between experience of debriefing and the knowledge measure approached significance ($r = .56$, $p = .056$). The researcher was interested in how many

of the participants who were debriefed had rated their experience negatively. The six lowest scores of the twelve participants who were debriefed, ranged between 40 and 55, out of a maximum score of 70 on this measure. Of the six participants who rated the debriefing experience as poor or average, two were unsure if they would attend another debriefing, and one participant felt pressured to talk in their debriefing session (two did not know if they felt pressured). Five of the six participants had experienced 4 or more critical incidents at Te Whare Ahuru.

Table 6

Correlations for debriefing status, and the attitude, knowledge, experience and outcome variables

Variables	Debriefing Status	Attitude	Knowledge	Debriefing Experience	IES-R	HSCL-21	Self-Rated Health	Job satisfaction
Attitude	.11 .67 $n = 18$							
Knowledge	-.81** .00 $n = 18$	-.30 .23 $n = 18$						
Experience Of Debriefing	a $n = 12$	-.17 .60 $n = 12$	.56 .06 $n = 12$					
IES-R	.13 .61 $n = 17$	.44 .08 $n = 17$	-.39 .13 $n = 17$	-.21 .52 $n = 12$				
HSCL-21	.38 .14 $n = 17$	.03 .91 $n = 17$	-.54* .03 $n = 17$	-.05 .89 $n = 12$	.62** .01 $n = 17$			
Self-Rated Health	-.02 .92 $n = 18$	-.48* .04 $n = 18$	.10 .68 $n = 18$	.24 .45 $n = 12$	-.27 .30 $n = 17$	.13 .63 $n = 17$		
Job Satisfaction	-.14 .59 $n = 18$	.02 .95 $n = 18$	.31 .21 $n = 18$	.11 .74 $n = 12$	-.57* .02 $n = 17$	.81** .00 $n = 17$	-.19 .46 $n = 18$	

a. Cannot be computed because at least one of the variables is constant.

**. $p < .01$ (two-tailed).

*. $p < .05$ (two-tailed).

Evaluation of the Debriefing Programme's Outcomes

Post-Traumatic Stress Symptoms – The Impact of Event Scale-Revised (IES-R)

Participants in the present study completed the IES-R to screen for any post-traumatic stress symptoms they may be experiencing as a result of critical incidents they were involved in at Te Whare Ahuru. The participants were asked to state how distressing each item had been for them during the last seven days. For the participants that completed the IES-R (n = 17), the mean total score was 19.00 (SD = 18.07), whilst the total mean scores for the subscales were 7.28 (SD = 7.11) for intrusion, 6.88 (SD = 5.77) for avoidance, and 4.83 (SD = 5.89) for hyperarousal. These sub scale results are is similar to those reported by Marmar et al. (1996) for a sample of rescue workers after a disaster. One person in the present study chose not to answer this measure. (Table 7 provides the means, standard deviations and range of scores for the outcome measures). The non-debriefed group had a higher mean total score (M = 23.24, SD = 26.46) than the debriefed group (M = 17.69, SD = 15.88). The mean difference between the groups is non-significant t (15) = -.52, p = .61.

As can be seen in Table 7 peoples' scores on the IES-R ranged from 0 and 61. A total of nine (52.9%) participants scored between 0 and 11. This was to be expected, as this scale measures post-traumatic stress symptoms, which are not common in the general population. Four people (23.6%) received high scores on this measure, ranging between 32 and 61. Table 8 shows the IES-R items that most people found to be distressing. Of the seven items found to be most distressing, four were intrusion items, two were hyperarousal items and one was an avoidance item. Even though most of the participants indicated a slight amount of distress on the IES-R, the high scores displayed by the two highest scoring participants, indicates they were experiencing high levels of distress. One of these two people was not debriefed at Te Whare Ahuru. A Pearson's correlation test (see Table 6) showed a non-significant relationship between debriefing status and scores on the IES-R.

Table 7

Descriptive statistics for the Outcome Measures

				Debriefed		Non-Debriefed		
Measure	***n***	***M***	***SD***	***M***	***SD***	***M***	***SD***	**Range of scores**
IES-R	17	19.00	18.10	17.70	15.90	23.24	26.50	0-61
HSCL-21	17	9.60	12.20	7.10	7.88	17.56	20.72	0-47.25
Self-Rated Health	18	3.82	0.62	3.83	0.69	3.80	0.45	3-5
Job Satisfaction	18	49.13	10.80	50.03	7.23	46.80	18.12	15-65

Psychological Distress – The Hopkins Symptom Checklist-21 (HSCL-21)

Participants were asked to complete the HSCL-21 to screen for levels of symptoms distress, by indicating how distressing a number of experiences had been for them over the past seven days. For the participant's who completed the HSCL-21 (n = 17) Table 7 shows the scores ranged from 0 to 47.25. One person chose not to answer this measure. The mean total score was 9.56 (SD = 12.17). The ratings of psychological distress were higher for the non-debriefed group with a reported mean total score of (M = 17.56, SD = 20.72), whilst the debriefed group (M = 7.10, SD = 7.88) were visibly lower. Although a higher number of staff in the non-debriefed group reported higher levels of psychological distress, the difference between the scores of the debriefed and non-debriefed groups was not statistically significant using a t-test for unequal variance t (15) = -.99, p = .39.

The scores on the HSCL-21 were relatively low, with nine of the participants who completed the measure scoring between 0 to 7.25, four participants scores ranged from 8 to 11 and four participant's scores ranged from 15 to 47.25. Table 8 shows the most distressing items on the HSCL-21 for the participants in the present study.

Table 8

Items participants found distressing on the IES-R and the HSCL-21 measures

IES-R	*n*
Any reminder brought back feeling about it	6
Other things kept making me think about it	6
I felt irritable and angry	5
Pictures about it popped into my mind	6
My feelings about it were kind of numb	5
I had waves of strong feelings about it	5
I had trouble concentrating	5
HSCL-21	
Blaming yourself for things	5
Feeling blue	4
Feeling inferior to others	4

Note. Maximum *n* score = 17

General Health – Self-Rated Health (SRH)

As shown in Table 7, participants in the debriefed and non-debriefed groups reported similar levels of self-rated health. This result shows there was no difference between both groups on their ratings of SRH and the mean difference for the debriefed and non-debriefed groups was not statistically significant $t\ (16) = .10, p = .92$. The range of scores was three to five. Two participants rated themselves as being in excellent health on the SRH measure. These same two participants had very low scores on both the IES-R and HSCL-21.

Work Stress – Overall Job Satisfaction

Participants in the present study were asked to complete the job satisfaction measure to screen for any dissatisfaction they might have been experiencing at Te Whare Ahuru.

All the participants in the present study ($N = 18$) completed this measure. Table 7 shows the mean total score was 49.13 ($SD = 10.79$). The debriefed group showed a somewhat higher level of job satisfaction ($M = 50.03$, $SD = 7.23$) than the non-debriefed group ($M = 46.80$, $SD = 18.12$). This indicates the debriefed group feel more satisfied with their job than the non-debriefed group. An independent samples t-test revealed the mean difference in overall job satisfaction between the two groups was not statistically significant, $t\ (16) = .56$, $p = .59$.

There were a range of scores on the job satisfaction measure, with 50% of the participants scoring between 15 and 51. Participants were dissatisfied with a variety of features of their job, as shown in Table 9. Many of the staff (66.6%) were dissatisfied with their rate of pay. Some of the issues people responded they were unsure about, on this measure included; industrial relations between management and workers (33.3%), the way the organisations is managed (27.7%), chances of promotion (22.2%), and recognition received for good work (22.2%).

Table 9

Job features participants were dissatisfied with on the job satisfaction measure

Features of the job	*n*
The physical work conditions	5
The freedom to choose your own work method	4
The recognition you get for your good work	6
Your rate of pay	13
Your opportunity to use your abilities	5
Industrial relation between management and workers	8
You chance of promotion	7
The way you organization is managed	7
The attention to suggestions you make	7
Your hours of work	6

Note. Maximum *n* score = 18

Relationships between debriefing status, the outcome measures and the demographic variables

As eight of the 16 participants in the present study were involved in critical incidents that involved attempted or completed suicides, their distress levels were examined, to see if any similarities were present. All of these participants had moderate levels on the IES-R and/or the HSCL-21. The participant with the highest distress level was not debriefed at Te Whare Ahuru, and five of these eight participants had been involved with the attempted or completed suicide within three months of filling out the questionnaire.

The non-debriefed group's mean total score showed high scores on the IES-R and HSCL-21, and a low score on the overall job satisfaction measure. Therefore, the non-debriefed group had high levels of distress and high levels of dissatisfaction with their job. It can be seen in Table 6, Pearson correlation tests showed a moderately strong, statistically significant correlation ($r = .62, p = .008$) between scores on the IES-R and HSCL-21. This relationship suggests that if the level of post-traumatic stress symptoms is high, the level of psychological distress will also be high. In the present study, six of the eight participants who scored in the top half of the HSCL-21 scored in the top half of the IES-R measure as well. Two of these eight participants were not debriefed at Te Whare Ahuru.

A statistically significant inverse relationship ($r = -.57, p = .02$) was found between scores on the IES-R and the overall job satisfaction measure, and a strong statistically significant, inverse relationship between the HSCL-21 and the overall job satisfaction measure was also found ($r = -.81, p = .000$). These relationships suggest the higher the level of distress, the lower the level of job satisfaction. The five participants with the lowest job satisfaction scores were in the top six most distressed scores on the HSCL-21. Also, two of the five participants with the lowest job satisfaction scores, were in the four most distressed scores on the IES-R. Only one of the five participants with low job satisfaction was not debriefed at Te Whare Ahuru.

Correlation tests were carried out between the IES-R, HSCL-21 and the knowledge measure to investigate whether a participant's knowledge of the programme was related

to their distress levels. A non-significant relationship between the IES-R and the knowledge measure was found, but a statistically significant inverse relationship (r = -.54, p = .03) between the HSCL-21 and the knowledge scale was found (see Table 6). This relationship suggests the higher the level of knowledge, the lower the levels of distress on the HSCL-21.

The data was examined to see if the seven participants involved with a high number of critical incidents (five or more), had low levels of job satisfaction and high levels of distress. As was expected, of the seven participants who had experienced many critical incidents, five of the seven had received one, or no debriefing at Te Whare Ahuru, three of the seven had rated their experience of a debriefing in the lower half of the range of scores for that measure, and two participants scored less than half on the knowledge measure. Four of the participants who had experienced many incidents had elevated distress levels on the IES-R and two had elevated distress levels on the HSCL-21. Four of the seven participants had low scores on the job satisfaction measure. Therefore, there is a consistent group of participants at the more extreme ends on many outcome measures, who had experienced many critical incidents, yet had received minimal debriefings. There were no significant differences between the two groups on any of the main outcome measures (except on the knowledge measure), in the present study.

Table 6 shows a statistically significant correlation was found between the amount of sick leave taken in the last six months and debriefing status (r = .52, p = .03). It suggests the lower amount of sick leave taken; the less likely a participant is to attend a debriefing. Three of the five participant who weren't debriefed were above the mean (1-7 days) for sick leave taken in the last six months. The participant who recorded the highest number of sick leave was not debriefed, had low levels of distress and a high level of job satisfaction. The relationship between sick leave and debriefing status could be moderated by other variables, such as knowledge, but the groups were too small to run any meaningful analyses on this relationship. Table 6 also shows the Pearson's correlation test between knowledge and sick leave approached significance (r = -.46, p = .054).

There was a statistically significant Pearson's correlation ($r = .74$, $p = .000$) between age and years work experience in the mental health field. This result was expected, as the age of a person tends to determine how long they have been working in a job.
A set of two-way between subjects ANOVAs were conducted with years of work experience and debriefing status as grouping variables and all the outcome measures as dependent variables. Owing to the small and uneven numbers in the demographic groups, no further analysis of the interactions was undertaken. There were no apparent differences between the demographics of the two groups, but these differences could not be tested statistically.

Outlier

Another big influence on the data set in the present study, besides the small sample size, was the presence of a multivariate outlier. It was decided to retain the outlier in the present study because of the participant's descriptive value. According to Tabachnick and Fidell (1996), one of the reasons for the presence of an outlier, is that the case is from the intended population, but its distribution of scores on measures is more extreme than in a normal distribution. Tabachnick and Fidell also say that deciding between deleting or retaining these types of outliers is difficult. It is believed the multivariate outlier in the present study fits this description.

The outlier appears to match the description of someone who should attend a debriefing at Te Whare Ahuru. They had been involved in numerous critical incidents, but had received no debriefings; they did not know about the debriefing programme, and had the lowest score on the knowledge measure. The outlier had the highest distress levels on the IES-R and the HSCL-21. They scored their self-rated health as good, and had the lowest score on the job satisfaction measure. However, even though the outlier had extreme scores on the measures used in the present study, there were four cases of debriefed people who had elevated scores (which were not far from the outlier's scores) on at least three of these measures.

When the data set included the outlier, the debriefing programme appeared to be effective in reducing psychological sequelae after critical incidents. The debriefed group had lower distress and higher job satisfaction than the non-debriefed group. Yet when the outlier was removed from the data set, the differences between the debriefed

and non-debriefed groups were not as obvious, and on some measures, the difference was negligible. Therefore, conclusions about the effectiveness of the debriefing programme were not possible, whether the outlier was present in the data set or not. It was originally thought that the outcome measures would be the main focus of the results section (and the present study). However, due to the small sample size and large number of non-significant results, the focus of the discussion will be on the results related to the process and impact of the debriefing programme at Te Whare Ahuru.

DISCUSSION

The present study was conducted via a questionnaire and consisted of seven measures and demographic questions. The purpose of the study was to conduct a baseline evaluation of the debriefing programme at Te Whare Ahuru. The current literature on debriefing is generally focused on the evaluation of outcomes, and is unfavourable about its effectiveness. However, this literature has focused mainly on individual debriefings, and has many methodological issues (Deahl, 2000). The present study initially focused on the evaluation of outcomes. This section discusses the findings from the present study with regard to the research questions that were posed, and the implications for Te Whare Ahuru. The most valuable finding from the present study is the importance of the process and impact of a programme, and including these variables in evaluation research. Process evaluation relates to the design and implementation of a programme, whilst impact evaluation relates to the changes that have occurred, such as impression or attitudes, which can lead to the proposed outcomes the programme predicted (McKenzie & Smelter, 2001). Conclusions will be made from these findings, and considerations for future research will be identified.

Results of the Process and Impact Evaluation

Did staff at Te Whare Ahuru get a debriefing when it was appropriate?

Responses from the staff at Te Whare Ahuru in the present study indicate they did not always receive a debriefing when it was appropriate. Only half of the participants who were involved in a recent critical incident were offered the opportunity to attend a debriefing. Most of the participants in the present study had been involved in at least three incidents, yet only two of them had received three or more debriefings at Te Whare Ahuru. There were a few participants who had been involved in 10 to 12 critical incidents at Te Whare Ahuru, and all received minimal or no debriefing. Clearly there is a great deal of disparity here between incidents occurring and debriefings being provided. This could indicate a problem in the implementation of the programme before it has even been conducted, and there are several reasons for this. Defusing might be used more frequently than debriefings, thus negating the need for a debriefing. Perhaps debriefing is not an appropriate response for staff at Te Whare Ahuru, and

defusing suits their needs better. However, this last point cannot be commented on, as the present study did not investigate defusing at Te Whare Ahuru. A lack of staff could also make attendance at a debriefing difficult. If there isn't enough staff to cover for those wanting to go to a debriefing, this provides a disincentive for staff members to attend altogether. The timing of the debriefing session is also a relevant issue for staff at Te Whare Ahuru, because most, if not all of the staff are shift workers. Therefore, an incident may occur on one shift, but the debriefing is held on another.

Another possible reason for the lack of debriefings occurring could be that staff chose not to attend a debriefing. However, the results of the present studyshow that the participants chose to attend debriefings when offered them, and those who were not given the opportunity, would have preferred to attend a debriefing. Only two people chose not to attend their debriefings. On-going debriefing or counselling was sought by three people. Most of the participants stated they had attended every debriefing offered to them. Interestingly though, three of these participants actually were stating intent to attend a debriefing, as none had been debriefed at Te Whare Ahuru before. This contradiction was made clear by the fact that all three participants belonged to the non-debriefed group. Perhaps the three participants from the non-debriefed group were indicating their intention to attend because all of their incidents had occurred within three months of filling out the questionnaire.

A further consideration is that debriefings are not being conducted because staff at Te Whare Ahuru don't feel safe to ask or talk at a debriefing. Staff may be reluctant to talk because they don't feel supported or listened to by management. The participants in the present study did indicate dissatisfaction with various features of their jobs at Te Whare Ahuru. It is important to acknowledge the importance of feeling comfortable and secure enough to request a debriefing. It can be a very difficult decision for some people to ask for help and support. They may fear being blamed or appearing incompetent, in front of their peers for not coping (Rolfe, 1998). Therefore, Te Whare Ahuru may need to investigate whether the organisation is providing a safe work environment so staff feel they can request help and not feel blamed.

The type of critical incident half of the participants named as their most recent, involved attempted or completed suicides of inpatients or outpatients of Te Whare Ahuru. All of

these eight participants had an average to high level of distress. Only half of these participants received a debriefing and three said a debriefing was not offered. Five of the eight participants' suicide related incidents occurred within three months of filling out the questionnaire. These levels of distress could be due to the fact that this was the participants' most recent incident, so the feelings associated with it were still fresh, or it could be because of the distress caused by the incident itself. This figure provides an indication of the types of incidents at Te Whare Ahuru. If attempted or completed suicides are the most common type of critical incidents occurring, Te Whare Ahuru may want to investigate the impact of that on their staff.

One participant commented the debriefing for their incident was held 15 days after the incident. The Hutt Valley Health debriefing folder (1999) says debriefings should be held within 48 hours of an incident occurring, yet the Hutt Valley Health company policy (Oct, 2000), which is based on Critical Incident Stress Management (CISM), states debriefings should be provided after 48 hours, and up to seven days after an incident. Unfortunately, the present study's questionnaire did not ask anything about the length of time it took to receive a debriefing. It could be appropriate to find out the experiences of the staff that did not respond to the questionnaire in the present study, to see if debriefings have been conducted after the one-week requirement on other occasions. This is a relevant issue related to the implementation of the debriefing programme, and in the current evaluative literature on debriefing (Dyregrov, 1997; Mitchell & Everly, 1995a).

Participants main source of information about the debriefing programme came from supervisors, and written information. It was good to find most staff knew about the debriefing programme. Eighteen participants responded to this question in the present study, but only eight participants found out from their supervisors about the debriefing programme. When it is considered that supervisors are one of the main people to ask for a debriefing, and only eight participants found out about debriefing from their supervisor, this number seems small. It could be argued that the reason for the small number is related to the fact that only one quarter of staff were receiving supervision at Te Whare Ahuru. Consequently, staff may be missing out on information, support, and encouragement that they deserve. Supervision is one way for senior staff to make sure employees at Te Whare Ahuru are coping and looking after themselves. Four

participants said they did not know Te Whare Ahuru had a debriefing programme, and none of these participants were debriefed at Te Whare Ahuru. Therefore, there are people who are missing out on the information about the existence of the debriefing programme. This could be because; they are new staff members, they were working on a different shift to the one the debriefing was held on, or there was no checking that staff knew of the debriefing programme's existence. However, there seem to be barriers to staff receiving supervision. One reason for this could be that it is hard for staff to get time off during work hours to provide supervision, let alone receive one.

What do the staff at Te Whare Ahuru know about the debriefing programme?

There were obvious group differences in the knowledge staff had about the debriefing programme at Te Whare Ahuru. This is well illustrated by the fact that four participants who had no knowledge of the debriefing programme had not been debriefed. These same four participants also said they were not satisfied with the information that was given to them about the debriefing programme, and received the four lowest scores on the knowledge measure. Surprisingly, a debriefed participant was also unsatisfied with the information they were given. It was thought that if a staff member attended a debriefing, they would be provided with all the information they needed about the debriefing programme. Two debriefed participants also stated they did not know, or were unsure, what a debriefing session involved.

Another issue was raised when participants were asked if they knew how to get a debriefing. Of the six participants who said they did not know or were unsure if they knew how to get a debriefing, four had not been debriefed and two had been debriefed. In other words, there were a few participants who had been debriefed, but they did not know how to get a debriefing. This might be because a debriefing was organised for their incident by the debriefing team, but this still means these participants do not know how to organise one for themselves. Most of the participants in the present study have indicated that debriefings haven't been offered to them, yet it is established at Te Whare Ahuru that staff are supposed to approach their supervisor or the debriefing co-ordinator, if they want a debriefing. The exception to this is when a very serious critical incident occurs and the debriefing team arrange a debriefing for those involved. It seems that confusion may exist with regard to how a debriefing is to be obtained. Burns

and Harm (1993) found that emergency nurses had a lack of information about the debriefing team and/or how to access them.

When enquiring about a support person for staff to talk to after a debriefing, seven participants did not know, or were unsure that there were support people available to them at Te Whare Ahuru, and outside of Te Whare Ahuru, in the form of the Employee Assistance Programme (EAP). This was surprising because the EAP has been established at Te Whare Ahuru longer than the debriefing programme, yet there are participants who don't know about it. A study on medical students helping out after a disaster found the student's lacked knowledge about support that was available to them (Kent & Kunkler, 1992).

The Hutt Valley Health mental health services policy (Dec, 2000) states that all Hutt Valley Health District Health Board staff (and other persons) involved in a critical incident were to be informed of defusing and debriefing procedures. However, this does not appear to be the case because some debriefed participants in the present study were unsure about information to do with the debriefing programme at Te Whare Ahuru. Also, the policy gives the impression that staff are not told about a defusing or debriefing until they are involved in a critical incident. There were four participants in the present study with poor knowledge who have never received a debriefing, yet were involved in numerous incidents at Te Whare Ahuru. It could be argued that waiting for an incident to occur is not an effective way of informing staff about the debriefing programme at Te Whare Ahuru. These four participants illustrate a problem, in that information about debriefing is not guaranteed to be passed on, even if a critical incident does occur. It may not be the case that staff were only told about defusing and debriefing after critical incidents, but the policy does not specify when staff are to be told about the programme outside of an incident occurring.

The knowledge measure highlights the importance of staff at Te Whare Ahuru having knowledge about the debriefing programme. It has clearly demonstrated disparities in knowledge between the debriefed and non-debriefed participants in the present study. The measure has also shown that some people in the debriefed group were lacking in knowledge about the programme, which was an unexpected finding. One debriefed participant in particular said they 'did not know' when answering all four items on the

knowledge measure. These issues clearly reflect problems in the implementation of the programme, and are affecting who receives a debriefing at Te Whare Ahuru. The results from the knowledge measure in the present study may have highlighted or pointed to an issue that actually affects all the staff at Te Whare Ahuru, not just the ones who did not receive a debriefing.

The company policy on CISM (Hutt Valley Health, Oct, 2000) states that full support must be given to staff during, and in the aftermath of, an incident. It does not expand on what full support actually encompasses, but it is assumed that involves a defusing or debriefing, as it is a policy based on CISM. Yet, the participants in the present study were not getting many debriefings. Some participants had little knowledge of the support available within the debriefing programme and the majority of participants indicated their willingness to attend a debriefing if one was offered. One way to help prevent the inconsistencies in the knowledge of the debriefing programme could be to provide an introduction to debriefing as part of an orientation package for new employees. This orientation package could be applicable to graduates and experienced workers who join Te Whare Ahuru.

How do the staff at Te Whare Ahuru feel about the debriefing programme?

The data in the present study indicated that most participants did not have to ask for a debriefing. This result could be because the debriefing was provided for them (as happens in serious critical incidents), or this could mean participants are not requesting debriefings. The fact that three participants had to ask for a debriefing is not necessarily a failure on the part of Te Whare Ahuru. It could mean the incident did not involve many people (not an uncommon occurrence) so debriefing needed to be requested, or the experience of the incident was only very upsetting for some members of staff, so they arranged a debriefing for themselves. Finally, the participants who had to ask for a debriefing could actually reflect a lack of support on behalf of Te Whare Ahuru, by not checking if staff are alright or wanting a debriefing. Unfortunately, the present study is unable to discuss the relationship between attitudes and debriefing status, and attitudes and the outcomes measures due to the measures' lack of reliability. The responses to the four items on this measure are still valuable though.

All 18 participants in the present study agreed that debriefing programmes had a place at Te Whare Ahuru. This was a little surprising as not all the participants had the experience of attending a debriefing, so they did not know what it would be like. It was also surprising as not all the participants had a positive experience with the debriefing programme (this will be discussed under the next research question). Nevertheless, this is a significant point as all the participants supported the idea of a debriefing programme at Te Whare Ahuru, regardless of their debriefing status or experience with debriefing. Many of the participants disagreed with the idea of dealing with their emotions from an incident by themselves, instead of in a debriefing. It was thought this was important because it inferred that most of the participants wanted help to deal with their emotions. Perhaps this help could be in the form of a debriefing session. However, just because four people did prefer to deal with their emotions on their own does not mean they don't like the idea of attending a debriefing.

What was the staff's experience of the debriefing programme at Te Whare Ahuru?
Most of the staff found debriefing at Te Whare Ahuru to be a positive experience. Positive comments included the debriefing was run well by the debriefing team, it made people feel at ease, and feel better. The favourable opinion of the debriefing reflects current evaluative literature on debriefing (Armstrong et al., 1998; Burns & Harm, 1993; Lane, 1993-94; Lee et al., 1996; Robinson & Mitchell, 1993). It is speculated that perhaps the debriefing is a structured time that provides participants with a forum to talk about their experience of a critical incident, and to help deal with their emotions (as many participants indicated they wanted to). (Bisson & Shepard, 1995; Kent & Kunkler, 1992).

All of the 12 participants who were debriefed in the present study were encouraged to attend a debriefing. This result shows that some of the processes related to the information distribution about the debriefing programme were working well. The majority of participants also expressed an intention to attend another debriefing if one was offered to them. This relates to the lack of compatibility between incidents occurring and debriefings being received. It shows that participants in the present study are choosing to attend debriefings. Therefore, this is not the reason for the discrepancy in debriefings being received by participants in the present study.

Interestingly, the debriefed participants who recorded high scores on the experience of debriefings measure each had almost equal numbers of incidents and debriefings. This seems to show that their needs for a debriefing after an incident were being met on nearly every occasion. These same participants also had good knowledge of the programme. Consequently, the programme appears to be working really well for a small group of participants in the present study. This could be because the participants are self-selecting and taking advantage of the debriefing being provided for them, or participants may be receiving supervision, support, and encouragement. Further research may be able to elaborate further on the reasons for these current findings.

Participants who were debriefed indicated a preference for a professional to be made available to them if they wanted to talk after a debriefing. Currently there is an EAP in place at Te Whare Ahuru, and the debriefing team do provide the option of a follow-up, which is in accordance with what the participants in the present study would like.

Even though the debriefing was generally viewed as favourable, there were also participants who did not have such a positive experience. A couple of participants stated they felt worse after the debriefing. This could be for numerous reasons, such as the implementation of the debriefing, the debriefing wasn't effective for them, or because it brought up feelings of the incident they were involved in which may have left the participants distressed or unsettled. A couple of the paraticipants did not like expressing themselves in front of others. This again could be related to the debriefing or someone's personal preference of dealing with stress.

An item related to timing of the debriefing showed two participants believed their debriefing was held too soon after the incident, and another participant commented it was held too late after the debriefing. These different responses with regard to the application of a debriefing reflect issues that are currently being examined in evaluative research into debriefing (Deahl, 2000; Dyregrov, 1997; Mitchell & Everly, 1995a). At the time of the present study, no consensus had been reached on the best time to provide a debriefing after a critical incident. Obviously it is very difficult to please everyone when it comes to designing a programme, as people are so diverse. Also, it is not

known if the participants who criticised the timing of their incident were referring to the same incident, as the questionnaire did not identify participants.

Other process issues came up when one person said they felt pressured to talk in the debriefing, and another stated the debriefers were intrusive. It is disappointing that a few participants said they had these experiences. Pressuring someone to talk in a debriefing goes directly against what Mitchell and Everly (1995a) advocated. A further consideration is that each debriefer from the debriefing team has a different style of providing a debriefing. Therefore, some of the negative experiences related to a debriefing may be a result of a debriefer's actions, and not the programme itself. A few of these issues are also reflected in Burns and Harm (1993) study with emergency nurses. Although a minority of participants were unhappy with different issues (some of the participants made more than one comment), they are important because they indicate that some participants were not happy with the debriefing they received at Te Whare Ahuru. Five of the six lowest scores on the experience of debriefing measure, were recorded by participants who had been involved in four or more critical incidents, but had received on average two debriefings each.

Two thirds of participants attended every debriefing offered to them at Te Whare Ahuru. However, some of these participants did not rate their experiences very highly. This was a curious find because if participants were unhappy, or did not like aspects of a debriefing, why have they attended every debriefing offered to them? One reason might be the need of a participant to talk about their incident, or perhaps the criticisms of their experience were only focused on a specific aspect of the programme, not the whole programme. Two participants did indicate on this measure that they did not know if they would attend another debriefing at Te Whare Ahuru, with one of them recording a poor experience of debriefing at Te Whare Ahuru. Overall, participants in the present study were positive about the debriefing programme at Te Whare Ahuru, which is one indication of a well-designed programme. However, the criticisms must be taken into account and a review of the application of the programme may be necessary.

One issue that should be addressed is the use of the same structure of debriefing for individuals and groups. The debriefing model, which is based on the Mitchell model of

group debriefing, is not intended for use with individuals as it relies on group processes and dynamics. Even though other researchers have used the Mitchell model with individuals this does not mean the model is being used correctly. Perhaps Te Whare Ahuru need to look at what to provide after critical incidents that only involve one staff member. It may be that the structure is inappropriate for individual staff and this could be one feature contributing to the high distress levels in participants in the present study. Regretfully, the present study did not enquire if participants attended group or individual debriefings.

Was there any relationship between a staff member's debriefing status, and their attitude to, and knowledge of, debriefing?

The knowledge measure turned out to be the strongest measure used in the present study. There was a strongly significant relationship between knowledge of debriefing and whether people were debriefed or not. Burns and Harm (1993) study on emergency nurses also found differences in the knowledge nurses had about the availability of debriefing teams. They concluded that information about critical incident stress and debriefing could be very important in minimising resistance to attend debriefings. The failure to show any relationship between attitudes and debriefing in the present study is largely due to the inadequate and unreliable attitude measure.

Was there any relationship between a staff member's debriefing status, and their psychological and physical health, and job satisfaction?

There were a small number of significant relationships between the outcome measures, but none between debriefing status and the outcome measures. However, there were important patterns beginning to emerge, with regard to the same participants appearing on the extreme ends on the outcome measures, which indicated high levels of distress and low levels of job satisfaction.

Scores on the IES-R and HSCL-21 were positively correlated and the non-debriefed groups scored highly on these measures. However, nearly half the scores on both measures reflected a minor amount of distress, with a few participants recording moderate to high levels.

It is interesting to note that some of the higher scores on the IES-R and HSCL-21 were recorded by debriefed participants. Six of the eight participants who scored above the median for HSCL-21 scored above the IES-R median. Yet, only two of these were non-debriefed participants. Therefore, it could be concluded that the debriefing programme does not work effectively with all its participants. Whether a participant was debriefed or not, there were participants who were recording noticeable levels of distress at Te Whare Ahuru, and this is of concern. It needs to be reiterated that this sample only reflects 36% of the staff at Te Whare Ahuru, so that the amount of distress participants have recorded cannot be generalised to represent all staff at Te Whare Ahuru.

The overall job satisfaction measure proved to be very informative. It had inverse correlations with both the IES-R and HSCL-21. This indicated that relationships existed between increased levels of distress, and decreased levels of job satisfaction. There were also participants with low distress levels and high levels of knowledge about the debriefing programme who recorded low levels of job satisfaction. Therefore, the scores on this measure showed that there were participants in the present study who were dissatisfied with a number of features of their job, regardless of their debriefing status. This measure has obviously tapped into important issues for some of the staff that work at Te Whare Ahuru.

There were a range of job features participants were dissatisfied with. Some of these fell into the category of what could be termed organisation issues. Participants were dissatisfied with the relationship with management, and how the organisation is managed. At least one third of participants expressed dissatisfaction with their chance of promotion and the hours they worked. The feature that provoked the largest response from participants was their rate of pay, with 66% of the present study being moderately or extremely dissatisfied about it.

Another point of interest were two items rated by at least one third of the participants. They referred to the recognition one gets for good work and the attention paid to one's suggestions. These items seemed to relate to how participants felt they were treated or validated in their job. The perceived high staff turnover at Te Whare Ahuru may therefore not be a result of working in a highly stressful work environment, but a result

of the perception of not being recognised or valued as employees at Te Whare Ahuru. The responses to these items may also be detecting the importance of social support for staff at Te Whare Ahuru. They also suggest that specific job features are important in determining participants' job satisfaction at Te Whare Ahuru in the present study. Further research into these features will better elucidate the reasons for these findings, and help provide solutions to the dissatisfaction felt by some of the staff at Te Whare Ahuru. Alpass et al. (1997) believe that identifying job features that lead to job dissatisfaction is crucial if organisations want to start being able to prevent poor psychological morbidity. Alpass et al. go on to say that organisations must provide a healthy and supportive work environment, which allows employees to make a meaningful contribution (Williams T., 1993)

The self-rated health measure was not as useful as was expected. In previous studies (Idler and Kasl, 1991) people's self-rated health was related to their actual physical health as assessed by medical reports and doctors assessments. In the present study there was little variability between the two groups, or even between the participants overall. There are four possible reasons for the lack of variability on this measure. Firstly, the predominant profession in Te Whare Ahuru are nurses, and they may have rated their health as average or good because their health is average or good in relation to the patients they care for (but they could still be in poor health). Secondly, a self-selection bias could be occurring, so the present study is missing out on those who really are unwell, as they are choosing not to respond to the questionnaire. The third reason could be the sample that is used in the present study does not represent the variability of the population at Te Whare Ahuru. Finally, participants may not be responding that they have terrible or poor health because the wording is too strong, and they don't identify with the meaning of those words. However, the two participants who rated their health as excellent did have low levels on the IES-R and HSCL-21.

Overall, it was disappointing the outcome measures were not more statistically useful. The data from the items within the outcome measures shows the same participants repeatedly appearing at the more extreme ends of the outcome measures, and some of these people were from the debriefed group.

When examining how the outcome measures related to the rate of critical incidents and debriefings, the results showed a consistent group of participants were involved in a high number of critical incidents. Half of this group had received a low number of debriefings, and also reported a high level of distress, and a low job satisfaction score. A few of these participants also had poor scores on the knowledge measure, and a poor experience of the debriefing programme. This finding emphasises the need to find out why some staff have never been debriefed at Te Whare Ahuru, when most of the participants have said they would attend a debriefing if they were offered one. Te Whare Ahuru also needs to find out why some of the participants in the present study have a lack of knowledge about the debriefing programme that appears to hinder their access to a debriefing.

There are convincing arguments in the literature for the introduction of stress education and pre-incident training for staff that work in jobs that are at a high risk for critical incidents to occur. (Bisson & Shepard, 1995; Mayhew, 1999; Mitchell, 1995 ; Mitchell & Dyregrov, 1993; Moran, 1998; Solomon, 1995). Education and pre-incident training could mean new employees would receive information about expectations of what sort of critical incidents they may encounter at Te Whare Ahuru, information about the debriefing programme and the EAP, and suggestions about how to cope with stress that is related to critical incidents. If Te Whare Ahuru provided all of this information to new employees, it may lead to staff feeling empowered, supported and secure. As a result, critical incidents may not be so disruptive in their effect on staff and the organisation, and staff would possess the knowledge to choose if they wanted to attend a debriefing (or arrange one if one was not offered).

Another option that may lead to increased knowledge, higher levels of job satisfaction, and lower distress levels could be to introduce a system where staff are paired up with a co-worker. This way, staff may feel more comfortable expressing themselves, or talking about issues that may be bothering them. It also could be a good source of information sharing. It would not be compulsory for staff to talk to this assigned co-worker, but the option would be available to them if they wanted it.

Was there any relationship between staff members attitudes to, and knowledge of debriefing, and their psychological and physical health, and job satisfaction?
A relationship was found between knowledge and general psychological distress that implied that lower knowledge was associated with increased levels of distress. This result provides another reason why knowledge seems to be important for participants in the present study. Knowledge of the debriefing programme appears to be related to the level of psychological distress a participant experienced and could be a powerful factor in disrupting the process of the debriefing programme.

A relationship was also found between debriefing status and the amount of sick leave taken in the last six months. This implied that a participant who wasn't debriefed was likely to have taken more sick leave. The present study could not comment on the influence the demographic variables may have had on the outcome measure, due to their small group sizes and the uneven splits within some of the variables. (Robinson, Sigman, & Wilson, 1997).

The present study has revealed the presence of some unhappy employees at Te Whare Ahuru, which needs to be addressed. Te Whare Ahuru does not have a large number of employees (approximately 42, with fluctuations in the medical staff). Consequently, any staff members that were distressed or dissatisfied with their job are especially important, as their unhappiness could be more apparent because of the small staff numbers, and influential on other staff members.

The company policy on CISM (Hutt Valley Health, Oct, 2000) states its purpose as providing support to staff and to reduce recovery time from an incident by restoring staff to normal function. Results from the present study suggest some of the participants may not have been restored to normal function, due to their elevated levels of distress and job dissatisfaction. No pre-test data was collected from participants in the present study, but the responses from the participants are helpful as they could be providing an indication of issues that Te Whare Ahuru may need to examine.

Management Issues

The process and impact of a debriefing programme are also strongly affected by the role and support of the management and policy of an organisation. There are many references in debriefing literature citing the importance of management's role in the successful implementation of a debriefing programme (Canterbury & Yule, 1995; Dyergrov, 1997; Everly et al., 2000; Figley & Kleber, 1995; Flannery et al., 1991; Mayhew, 1999; Mitchell, 1995; Parkinson, 1997; Robinson, 1995; Solomon, 1995) The attitudes, level of support and way in which the debriefing programme is presented can influence the way debriefing is received by staff. Management are also important in the planning and design stages of a debriefing as they help determine the policy an organisation will use for setting up their debriefing programme.

The company policy for Hutt Valley Health (Oct, 2000) provides a support package (in the form of CISM) for staff to help them cope with the aftermath of a critical incident. This is an acknowledgement that debriefing alone is not enough to minimise psychological morbidity after an incident, as support needs to come in many forms (Robinson & Mitchell, 1995). This can depend on the circumstance of the incident and the people involved in it. The inclusion of non-staff being able to access debriefings under the mental health services policy (Dec, 2000) is also very positive. This reflects an understanding that the effects of an incident are not just confined to those directly involved (Deahl, 2000; Mayhew, 1997; Williams T., 1993).

There are issues though, that Te Whare Ahuru needs to address. The goals of a debriefing programme need to be standardised so that management and staff are working towards achieving the same results. Hutt Valley Health have a company policy (Oct, 2000), a mental health services policy (Dec, 2000), a debriefing folder (1999) with an older debriefing policy inside that (1998), and a booklet that is handed out in debriefings to staff, which all state slightly different purpose and objectives for the debriefing programme. Te Whare Ahuru needs to find out if the goals that have been set for the debriefing programme are being achieved. Whether the aim was to restore staff to normal functioning, minimise stress or lesson the impact of an incident, the results from some of the participants in the present study indicate that these goals are not being achieved.

Margaret Mitchell (1999) explains that objectives for a debriefing programme can be set in the form of the individuals and the organisation. They must be explicit and be able to be evaluated to see if the goals are being met, so comparisons can be made and improvements undertaken if necessary. Mitchell then adds, it is only when aims are clearly stated that evaluations can be conducted effectively.

The lack of any formal evaluation of the debriefing programme at Te Whare Ahuru is a problem. This programme was set up four years ago to help support staff, minimise psychological morbidity and, hopefully improve staff morale and job satisfaction, but no investigation was conducted to see if any of these goals wee being achieved. The evaluation of a programme is just as important as the design of it, and should be planned when a programme and policy are set up (McKenzie & Smeltzer, 2001). Evaluation should be on going and needs to be supported by management. Te Whare Ahuru need to know if the debriefing programme is achieving what it was designed for, if it is cost-effective, if staff are happy with the programme or if it is detrimental to the health of their staff. It needs to be established why no formal evaluation has been conducted before the present study, and why it wasn't set up when the programme was implemented. If there was a perceived need for the debriefing programme in 1998, why has no one questioned the low number of debriefings that have been occurring, in a high stress work environment, like that at Te Whare Ahuru?

The debriefing team had one piece of evaluation in place at the time of the present study. They had constructed a feedback form that was given to all staff after they attended a debriefing. These evaluations are collected and reviewed at the debriefing team monthly or bi-monthly meetings. It is important that the information is recorded and to give attention to what staff have to say about their experience of debriefing. Te Whare Ahuru also needs to find out if any suggestions from these feedback forms are being followed up. The feedback form is a good start towards evaluating the debriefing programme and would provide useful information on some of the process and impact features of the programme. However more formal evaluation needs to be undertaken to find out if the process of the debriefing is being implemented as the company policy (Oct, 2000) and mental health services policy (Dec, 2000) both stipulate. Any problems with the process or impact of the debriefing programme need to be identified, for

example, if the programme is not achieving all of its goals, or if staff are showing signs of elevated distress or job dissatisfaction. This may mean reviewing the debriefing policies, or the design of the programme, and setting up some on-going evaluation of the programme.

The debriefing folder that was developed for the debriefing team was out of date at the time of the present study. Both the debriefing team and debriefing policy had changed since its inception in 1998 and needed to be updated with the new policies and debriefing team members. This folder is an important source of information for staff, and participants in the present study have shown a lack of knowledge about debriefing does exist at Te Whare Ahuru. Therefore, leaving an old copy of the folder for staff to read could be perceived as not placing much importance on the use of the debriefing programme. Also, because it is an important source of information for staff, perhaps more copies of it should be available, instead of just one copy in the nurses' station on the ward at Te Whare Ahuru.

There does not appear to be any quality control measures in place at Te Whare Ahuru to ensure the debriefings are given in a fair and consistent manner. Therefore, Te Whare Ahuru doesn't know if staff are receiving a debriefing delivered in the structure laid out in the company policy (Oct, 2000), mental health services policy (Dec, 2000) and the debriefing folder. This is part of process evaluation because whether a programme works or doesn't work, Te Whare Ahuru need to know why. Problems could be related to the design or delivery of the programme, but without evaluation, the source of any problems is unknown. Other evaluation issues revolve around whether any barriers exist that affect the implementation of the programme because there is no point putting a programme in place, which costs time and money, without a well-planned evaluation being conducted.

Another important issue that management needs to address is the inadequate training the debriefing team had received. The Hutt Valley Health mental health services policy (Dec, 2000) clearly states the debriefing team will be trained by an independent trainer, and receive on-going training and supervision throughout the year. At the time of the present study, the debriefing team had received two training sessions since its inception in 1998. The training sessions were held three years apart and the first session was half

a day long, the second was four days long. This lack of training could be compromising the quality of the debriefings staff are receiving at Te Whare Ahuru, and possibly lead to increased distress levels. Mitchell and Everly (1995a) state that the training a person receives is important as it can create problems with the process of the programme if it is not done correctly.

Another important point to add to this is that there has been a high turnover of debriefing team members, with only four of the original fifteen or so members still on the team. Therefore, most of the debriefing team have only received one training session. It could be suggested that one reason staff may be leaving the debriefing team (apart from a change of job) is the lack of training or support being received, and a lack of understanding about the how the debriefing programme is supposed to work. There are obviously barriers to staff receiving training, as the policy has stated that there was an intention for staff to received more training than they have. One barrier could be related to the funding of such training, or the importance placed on training by management.

Limitations

Although the present findings have contributed some very valuable information about the process and impact of the debriefing programme at Te Whare Ahuru, there are several limitations to the study that must be acknowledged.

Participants

Access to the participants was more difficult than anticipated. A meeting with representatives from Te Whare Ahuru at the beginning of the present study confirmed support and financial remuneration for travel and photocopying expenses, and that Te Whare Ahuru employed 50 staff, who would be the participants in the present study.

There were several delays before the researcher could begin to undertake the data collection at Te Whare Ahuru, these included waiting for written approval to be able to undertake research at Te Whare Ahuru, and gaining permission from an ethics committee which was not mentioned when the research into the present study began.

Difficulties also arose when the clinical psychologist who initiated the research left her job at Hutt Valley Health. At times it was hard to get information about Te Whare Ahuru and the debriefing programme, as some staff members were hard to get hold of. Time was also lost trying to arrange a time to hand out the questionnaires to the staff at Te Whare Ahuru.

Due to these unexpected delays, data collection took place five months after the intended date, which left the researcher only one month to collect the data. Just before the data collection the researcher found out that the sample size was smaller than she was initially led to believe. There was a small turnout when the researcher handed out the questionnaires, so most of the questionnaires ended up being sent through Te Whare Ahuru's internal mail system, which was not the preferred method of delivering the questionnaires because it was an impersonal way of making contact with the research sample, and participants could not ask the researcher any questions about the present study if they had wanted to. The short time frame to collect the data could be one reason for the poor response rate (18 people) in the present study. Another reason for the poor response rate could be that the data were not collected until three weeks before Christmas. Usually at this time of the year people are tired and busy, so filling out a questionnaire might not be a high priority for them.

After the data collection, the researcher was informed that Te Whare Ahuru was not the only place the debriefing programme was provided. It was also offered to staff at all three community bases affiliated with Te Whare Ahuru, and on the general ward at Hutt Hospital. This information was crucial to the set up of the present study and would have meant the researcher had access to a bigger sample and may have received a better response rate. The researcher was also not told about the feedback forms the debriefing team gives out to staff after attendance at a debriefing, until after the data collection in the present study. No financial remuneration for travel or photocopying expenses was ever received.

When staff were asked their thoughts on why their colleagues might be so reluctant to take part in the present study, the researcher received several reasons. Firstly, there was no commitment to research (including evaluation) on the part of the staff or management at Te Whare Ahuru. Secondly, staff were apathetic and not feeling

empowered. Thirdly, staff didn't believe any changes would be made to the programme as a result of the present study. Finally, staff at Te Whare Ahuru may have been reluctant to fill out the questionnaire because it was handed out too long after a critical incident had occurred. As a result, the experience was not fresh in the minds of the staff that were involved in it. It is interesting to note that Beavan, (1998) faced similar difficulties in her research with nurses who worked on an accident and emergency ward, which also resulted in a poor response rate.

Due to the small sample size, it is not appropriate to generalise the results of the present study to represent all of the staff at Te Whare Ahuru. The small sample size also compromised the statistical analyses that could be conducted on the data in the present study. Small sample sizes are not uncommon in debriefing research (Beavan, 1998; Berah et al., 1984; Lee et al., 1996; Watson & Feld, 1996). Despite the sample size, participants provided some valuable information on the process and impact of debriefing at Te Whare Ahuru.

Management

The lack of communication and support shown by management for the present study was disappointing, especially when it is considered that a representative from Te Whare Ahuru approached the researcher to conduct the research. The present study has illustrated the importance of having management support in conducting any type of research in an organisation, and showing this support to the employees as an indication that the research is worthwhile and important. If management doesn't appear to support any research being conducted in an organisation, then the staff may not either. The researcher suggests that this may be the case in the present study.

Measures

The use of retrospective data and self-report measures does create some disadvantages, such as inaccuracies associated with self-assessment and memory recall (Jones, 1985). In the present study some of the critical incidents participants were asked to recall occurred over six months before the questionnaire was handed out. A social desirability

bias may also have been present; therefore the participants may have answered more favourably than was actually true, because they did not want to appear distressed or unhappy. However, retrospective data was a more efficient form of data collection and tapped into opinions and experiences that may not have otherwise been obvious.

The lack of a reliable attitude measure in the present study meant no conclusions could be made about the relationships between attitudes and any of the other variables in the present study. An attitude measure needs to be developed that has sound reliability and correlates well with the knowledge measure used in the present study. The phrasing of some of the items in the measures that were developed for the present study were vague or ambiguous as reflected in some of the participant's responses. A pilot study of these items could have identified some of these issues earlier, but due to the unexpected delays in the access to participants there was no time to run one.

Methodology

There were several methodological flaws in the present study. The main reason for this was because the research setting and the participants were already set up and in place. This is because the present study used participants from an established work environment and policies. The participants were not randomised into debriefed and non-debriefed groups as the debriefing programme is voluntary, and it would have been unethical to withhold debriefing from some of the staff as it is viewed as a support programme for staff.

There were uneven groups of debriefed and non-debriefed participants in the present study, which made some of the statistical analyses hard to conduct. However, even if a larger sample responded to the questionnaire, there still may have been an uneven distribution of debriefed and non-debriefed participants. This could be a result of the differences in knowledge about the debriefing programme that some of the participants had in the present study. Another limitation to the present study is that the participants were also involved in a range of critical incidents, and were made up of a variety of occupations. However this could not be helped as the questionnaire was anonymous and there were so few participants that it was inappropriate to break them into smaller sub-

categories. It is acknowledged that the effectiveness of debriefing may be different for different occupations, but this was beyond the purpose of the present study.

There was a time delay of up to six months between an incident occurring and a participant filling out a questionnaire. Therefore it needs to be acknowledged that other factors (besides critical incidents) could have produced the elevated distress levels and low job satisfaction found in some of the participants in the present study. No follow up evaluation was able to be conducted because the questionnaires were anonymous.

However, although there were several limitations to the present study, they do not overshadow the importance of the findings from the participants. This research was intended as a baseline study of the debriefing programme at Te Whare Ahuru, and there is opportunity for further development of the findings in the present study.

Future Research

Te Whare Ahuru

More evaluation needs to be conducted on debriefing to see if the programme is effective, and to explore issues that were brought up by the present study, such as the lack of knowledge of debriefing in some of the participants. As the present study was only representative of 36% of the staff at Te Whare Ahuru, future research would be need to be conducted on a bigger sample to increase generalisability. This research would include the three community bases and the general ward at Hutt Hospital that also have access to the debriefing programme.

There is also a place for qualitative data when assessing the debriefing programme at Te Whare Ahuru. More open-ended questions could expand on the participants' responses in the present study and provide more in-depth information on such issues as why participants were dissatisfied with specific aspects of their job or why participants were unhappy with their debriefing experience. Qualitative data would also allow participants to add any comments they felt were relevant to the research that weren't addressed in the present study. Longitudinal research, especially in relation to PTSD would be

useful, as the development of PTSD is only recognised after the symptoms have been present for one month (APA, 1994)

Further research on the staff at Te Whare Ahuru could also evaluate the different stages of a debriefing, to try and determine where problems with process and impact may be occurring. It would also be relevant to ask staff if they felt Te Whare Ahuru prepared them to deal with critical incidents and what they think Te Whare Ahuru could provide for them that would help them to feel supported.

A survey of management's attitudes toward the debriefing programme would be appropriate, given their reluctance to provide some support for the evaluation on debriefing in the present study. This could be compared with the staff and debriefing team's attitudes toward debriefing, to detect if any difference in the value or necessity of the programme existed.

Investigations could be conducted on why barriers appear to exist in the distribution of knowledge of the debriefing programme and why there is perceived to be a high turnover of staff on the debriefing team and on the staff at Te Whare Ahuru. Future research could also expand on the demographic questions, for example to include specific information on the occupations of the staff within Te Whare Ahuru. This may provide information on any differences that may exist between the various occupations on the knowledge measure, or the distress and job satisfaction measures.

Psychological trauma in the workplace

If evaluation research finds the debriefing programme at Te Whare Ahuru does not meet its goals to minimise psychological distress and return staff to normal functioning, management will still need to provide help and support for their staff in another form. This is because the present study has shown staff appear to be exposed to a reasonable number of critical incidents as a result of the type of work they do at Te Whare Ahuru. A prevention programme is also recommended because of the psychological and physical effects that have been associated with the aftermath of critical incidents, such as PTSD, for which there is no currently agreed upon treatment (Van der Kolk, 1996). Therefore, preventative programmes seem to be the wisest option for organisations to help support their staff.

Prevention of psychological sequelae is important because of the issue of vicarious traumatisation (which is now a diagnostic feature of PTSD, according to the APA, 1994), especially in occupations that face repeated exposure to critical incidents. The effects of cumulative trauma on employees in high-risk occupations have not received too much attention in the debriefing literature. Therefore, it would be interesting to undertake research into this emerging area with the staff at Te Whare Ahuru.

CONCLUSION

Critical incidents can occur at any time and are often sudden, frightening and very distressing. Sometimes these incidents can be so devastating people can become traumatised, which can lead to the development of psychological and physical health problems that directly impact on a person's life. Psychological debriefing is a preventive intervention designed to minimise the impact of critical incidents on those who are exposed to them. A large amount of evaluation has been conducted on the effectiveness of debriefing programmes, but most of the literature has found debriefing to have no discernable effect in minimising psychological sequalae after critical incidents. However there are many issues in this literature, which relate to the methodology and application of debriefing, which need to be addressed.

Whenever a programme is designed, evaluation needs to be conducted to see if it is achieving goals. The effectiveness of a programme cannot be determined without an evaluation of it. The present study was the first formal evaluation of the debriefing programme to be conducted at Te Whare Ahuru. Even though there were delays and communication problems between the researcher and management, permission was granted to carry out the research, which led to some worthwhile findings.

The most important finding in this evaluation was related to the descriptive information about the process and impact of the debriefing programme at Te Whare Ahuru. Most of the staff appeared to have a positive experience of the debriefing programme. However, there were problems with the amount of knowledge staff had about the debriefing programme and the delivery of the programme. Results also showed high levels of distress and job dissatisfaction in some of the participants.

More support from management may have increased participation in the present study, which may have led to a bigger sample size. Future research could further explore the issues that were found in the present study, and lead to a better understanding of the debriefing programme at Te Whare Ahuru.

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Yule, W. (Ed.). (1999). *Post traumatic stress disorders: Concepts and therapy.* England: John Wiley & Sons.

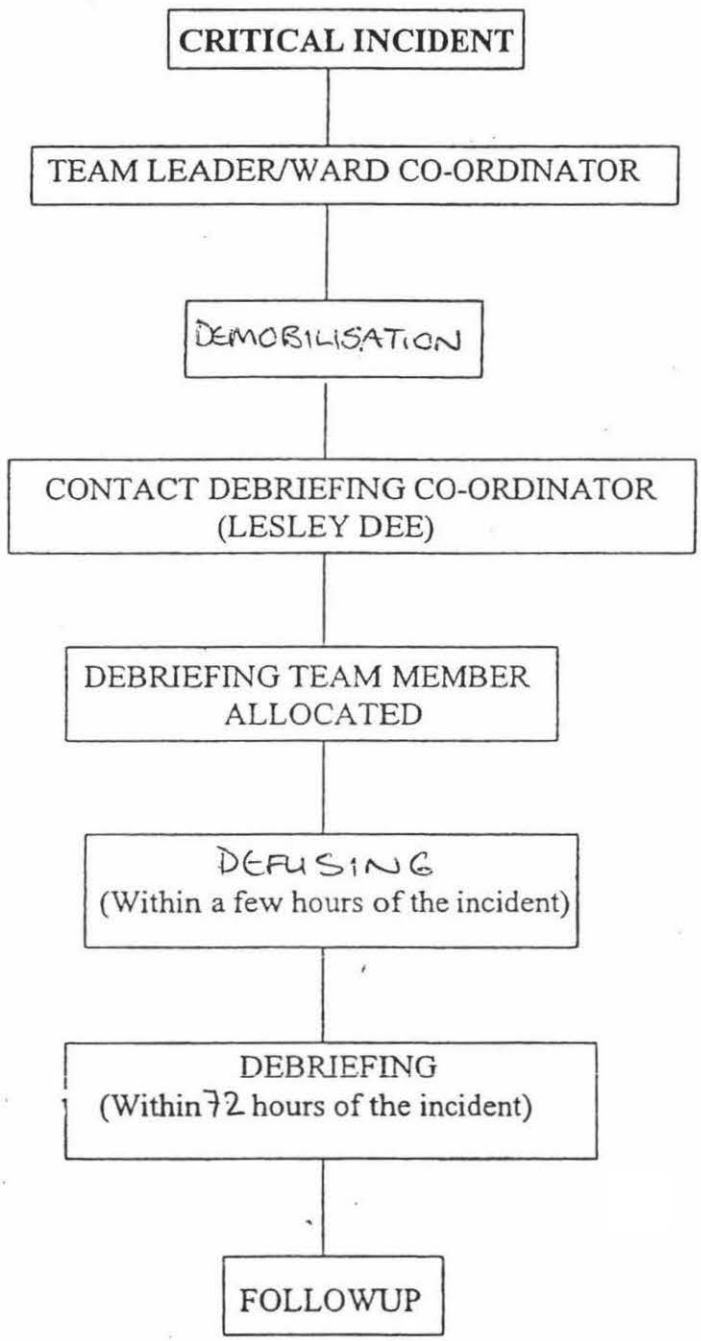
Appendix A

Te Whare Ahuru debriefing folder

CONTENTS

DEBRIEFING

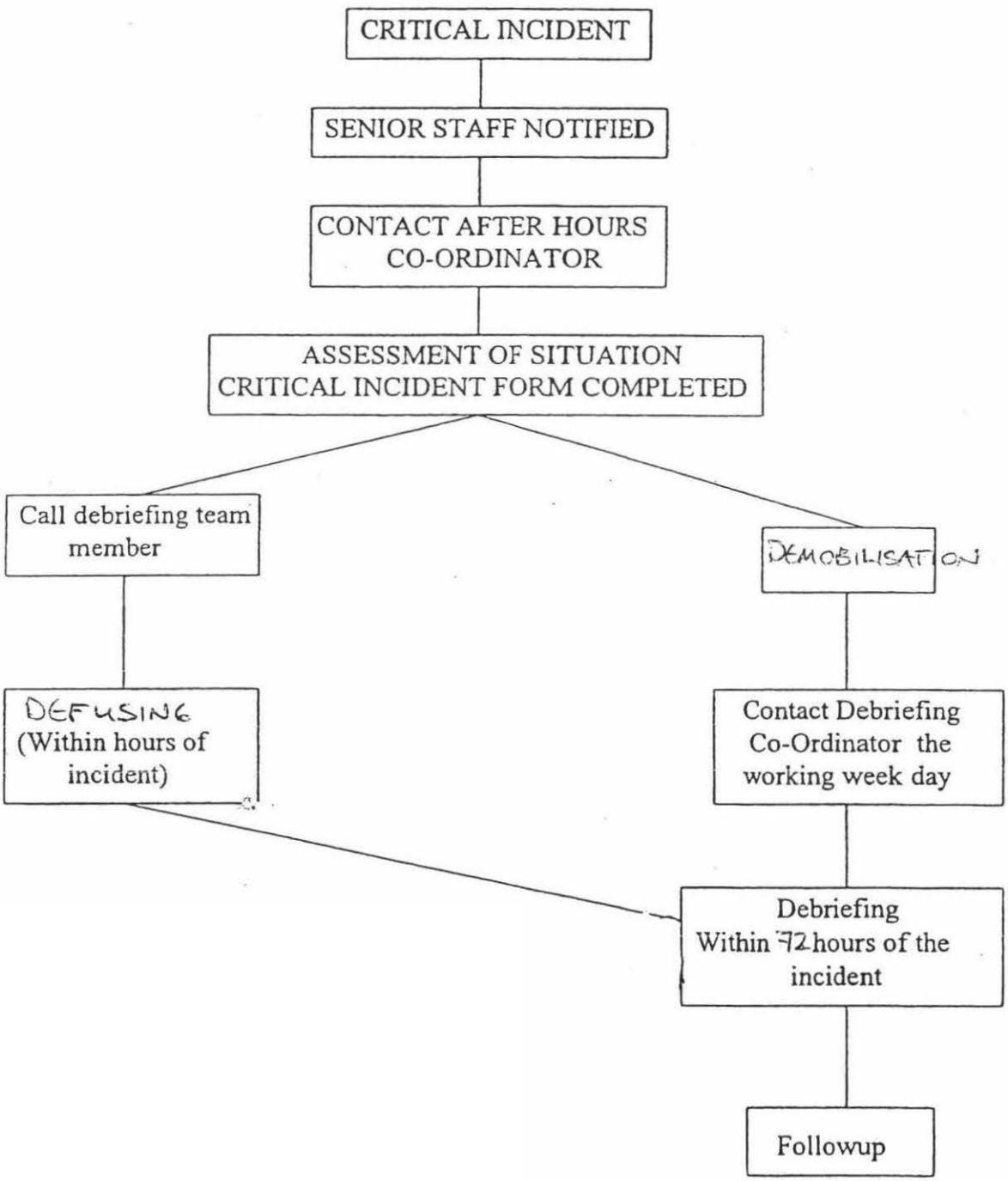
(8-00 a.m. - 5-00 p.m. Mon-Fri)



DEBRIEFING

5.00 p.m. - 8-00 a.m. WEEKDAYS

SATURDAY & SUNDAY



Debriefing Team Members

Lesley Dee	Co-ordinator	Sovenz House Phone: 570 9839
Anne Rose	Nursing Development Unit	Phone: ext 9139
Carol Brewer	Child & Family Service	Phone: ext 9601
Faye Haerewa	Emergency Department	Phone: ext 9168
Graham Bull	Social Work Department	Phone: ext 8318
Grenville Hendrix	Te Whare Ahuru	Phone: ext 8907
Hanny Naus	Social Work Department	Phone: 564 5705
Jackie Khan	Te Whare Ahuru	Phone: ext 8034
Kiri Summers Ngaio Taylor Puawai Thompson	Maori Mental Health Upper Hutt CMHT	Phone: 570 9801 Phone: 528 5595 Phone: ext 9042
Sarah Dohrn-Schnellenberg	CAFS / YSS	Phone: ext 8159
Sue Cade	Acute Day Service	Phone: ext 8159

DEBRIEFING TEAM MEMBERS:

*	**LESLEY DEE**	Co-Ordinator	Knights Road, Lower Hutt Phone 566-4596
*	**DALE FOWLER**	Liaison with General Hospital	Te Whare Ahuru Ph 5666-999 Ext or Page
	CLIVE BAYLISS	Child & Family Service	Phone 569-8422
	GRAEME BEAUMONT	Knights Rd, Lower Hutt	Phone 566-4596
	SUE CADE	Acute Day Service	Phone 5666-999
	MARLENE FITZGERALD	Community Mental Health Upper Hutt	Phone 528-5595
	ROIMATA FLUTEY	Hinetitama Alcohol & Drug	Phone 566 4596
	KIM HENNEKER	Community Mental Health Waikare	Phone 569-6492 (Hours available Monday 9-00 am -12 noon Tues, Wed, Thurs, - 9-00 am - 3-00 pm
	JACKIE KHAN	Te Whare Ahuru	Phone 5666-999 or page
	RACHEL PREBBLE	Community Mental Health Waikare	Phone 569-6492
	NGAIO TAYLOR	Community Mental Health Upper Hutt	Phone 528-5595
	KAHU WILLIAMS	Community Mental Health Waikare	Phone 569-6492

HUTT VALLEY HEALTH

MENTAL HEALTH DIVISION

CRITICAL INCIDENT STRESS MANAGEMENT PROGRAMME

BACKGROUND

Critical incident stress can result from any situation that causes people to experience unusually strong emotional reactions, which can have the potential to interfere with their ability to function at the scene or later, at work place.

As the management of Mental Health Services take seriously the cost to individuals, staff and patients a C.I.S.M. programme is to be instituted throughout the Mental Health Services.

As part of this programme staff will be trained in peer defusing and debriefing.

WHAT ARE DEFUSING AND DEBRIEFING?

They are tools for preventing and alleviating symptoms or feelings of distress created by a critical incident. The intent is not to replace ongoing professional counselling or supervision. The actual debriefing is a psychological and educational discussion group using a specially trained group of peer supporters and, when necessary, trained mental health consultants.

THE PROCESS

The process helps staff involved in the critical incident by mitigating or lessening the impact of the event. It provides peer support and encouragement, and ventilation of feelings. This should be carried out within forty-eight hours of a critical incident occurring.

THE GOALS

The goals are to:-

1) shield the staff member from additional stress;
2) help organise and mobilise resources;
3) return each person to their pre-crisis level of functioning; and
4) help clarify the overall picture of the event.

WHO ARE THE DEBRIEFING TEAM MEMBERS

The peer support team are colleagues who have undergone a short training programme to enable them to provide support to other staff after critical incidents. The defusing process is a session in which staff members are encouraged to discuss the event and the effect that it has had on them. If the team decide that the incident is more complicated and/or effects them personally, outside trained consultants will assist.

Names and phone numbers of each Debriefing Team Member are located in this file.

DEFUSING SKILLS CHECKLIST

INTRODUCTION:
* Who you are
* What is your role?
* Confidentiality
* Create safe support

DISCUSSION:
* Allow staff member to tell her/his story
* Allow for feelings to be expressed
* Notice "unusual" symptoms

EDUCATION:
* Provide information about stress responses
* Discuss recovery

SUPPORT:
* Help with tangible items (eg. getting home)
* Encourage the group to provide support

FOLLOW UP:
* Encourage attendance at formal debriefing if necessary
* Arrange to see the person again

DEBRIEFING SKILLS: A CHECKLIST

INTRODUCTION:
* Build rapport
* Discuss rules of the process
  - Confidentiality
  - Speaking for self
  - Psychological debrief

FACT PHASE:
* People give facts about (i) the incident
  (ii) what they saw , heard, did etc
* Additional information recounted

FEELING PHASE:
* People express how they are feeling about the incident
* How did you feel?
* What happened inside you?
* What did you find yourself doing?
* What happened as you talk about it now?

SYMPTOM PHASE:
* What unusual things did you notice happening to you at the time?
* What have you found it difficult to do since the incident?
* What things are different now?
* What other ways has your life changed since the incident?

TEACHING PHASE:
* Provide information about stress responses and stress reactions
*Talk about what is natural and "normal about these reactions
* Give some expectation of return to normal functioning

RE-ENTRY PHASE:
* Answer any questions
* Provide assurances
* Offer to provide information to partners, family etc.
* Plan further action
  * group support
  * dealing with future "what ifs"
  * memorials
  * handling questions from others

FOLLOW UP:
*Arrange a time

Critical incidents in the workplace

Stress at Work

Stress is often used to describe one of the pressures that is experienced by people in their everyday living. When it is applied to work it is called *Occupational Stress.*

A major feature of occupational stress is the build up over time. If an individual does not have effective ways of managing this general tension more serious problems can arise.

Critical incident stress (CIS),is a related form of stress which arises from any situation or event which cause the individual to have strong emotional reactions as a result of the incident. The incident can make overwhelming demands on a person's ability to cope, particularly in the short term. Being required to cope with accidents and/or other emergency situations are common causes of critical incident stress.

In the days, and possibly weeks after a such an incident, people report a variety of experiences. These may include moderate to high levels of anxiety and general apprehension, as well as a sense of despair and detachment. Other reactions, such as anger and depression may occur, as may sleep disturbance, poor concentration, nervousness, and feelings of insecurity. Physical discomfort in the form of muscle tension, headaches, nausea and indigestion have also been reported.

With understanding and support from colleagues and family, these stress reactions usually pass within a short time.

Sometimes an individual may experience an incident which is particularly disturbing. Even though the incident may be over the effects may not be for an individual. Sometimes people experience aftershocks as a result of thinking about, or remembering the event. This is experienced as a ***post trauma stress reaction.*** Once the incident has long passed some people find they are haunted by disturbing memories that interfere with coping abilities on a day-to-day basis. It is the disturbing memories that trigger the stress reaction.

Why do people have these reactions?

Most people live their lives in a steady state, which indicates some degree of harmony in between their thoughts, feelings and physical needs. This state tends to continue as long as there are no major interruptions from outside factors. Such an interference is called a *"crisis"*.

The type of crisis which brings about critical incident stress is usually a sudden traumatic event, or a series of events. Few people are immune to this type of stress. However, there are a wide range of ways people manage the stress.

Symptoms of critical incident stress

Psychological distress following a critical incident *may include* the following:

SUPPORT SKILLS

1. Prepare to Listen
2. Show Interest
3. Listen Carefully
4. Focus Attention
5. Wait - think - respond
6. Sharing of Self
7. Be Honest
8. Observe Incongruency

Listening Skills

1. Eliminate external distractions
2. Eliminate internal distractions
3. Respond to content, intent, and non-verbal communication
4. Identify your own triggers and bracket these off
5. Be non-judgemental
6. Be open minded
7. Make up your own mind in the situation
8. Move towards the person a little if you are having difficulty listening

Factors which can influence the extent of trauma reactions.

1. Severity of the stressor.
2. Duration of exposure to stressor.
3. Personality pre-disposition.
4. Prior trauma experienced.
5. Support systems available.
6. Degree of control capable.

Reactions following a critical incident.

1. EMOTIONAL (feelings)
   fear, apprehension, anger.

2. COGNITIVE (thinking)
   memories, dreams, sudden recall, rumination.

3. PHYSIOLOGICAL
   autonomic changes, illness.

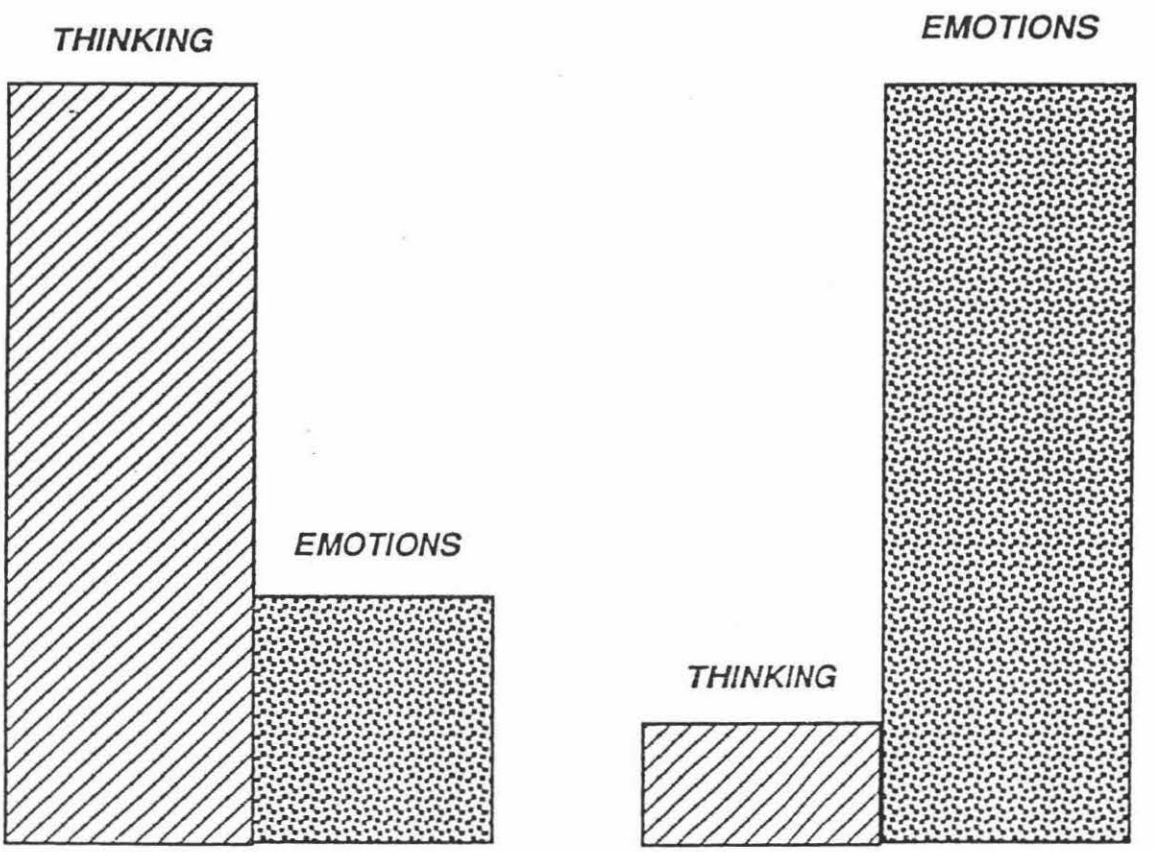
4. BEHAVIOURAL
   sleep disturbances, mood swings, poor concentration, agitation.

CRISIS

Opportunity Riding on a Dangerous Wind

The Support Function

Mental processes in normal and abnormal situations.



STRESS

A physical / emotional state of discomfort which occurs when the demands made on a person overwhelm that person's ability or resources to cope.

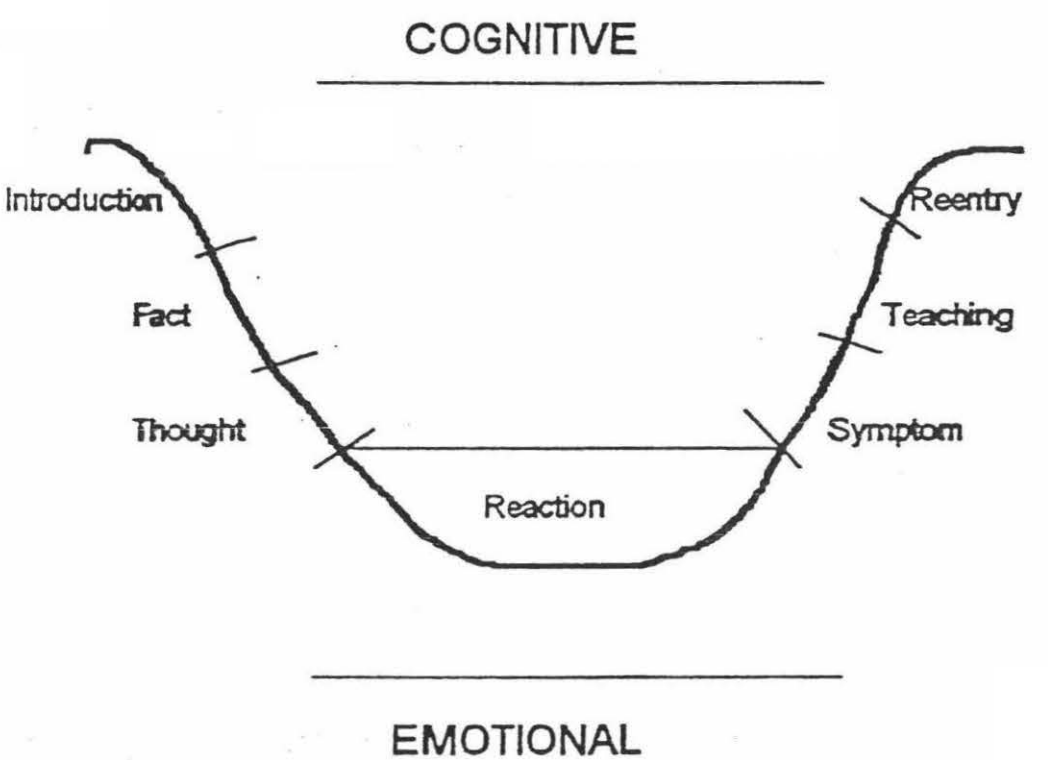
CRITICAL INCIDENT STRESS

The reaction to demands which are sudden, unexpected and due to a specific incident or set of incidents.

POST TRAUMATIC STRESS

A reaction due to dealing with the memories of a traumatic event or incident and its associated stress.

THE CRITICAL INCIDENT DEBRIEFING PROCESS



In the Aftermath of Traumatic Incidents: What is Peer Support?

From time to time, a wide range of people in the community are subjected to incidents which are sudden, unexpected and overwhelming. The reaction to such events is often referred to as *Critical Incident Stress*.

When exposed to incidents which place great strain on human coping ability, very few people are immune. In many situations, one doesn't have to look past their own workplace to find evidence of the way in which serious and disturbing events affect the functioning of those involved. Occupational health people often report problems of absenteeism, job performance difficulties, task avoidance, workplace arguments and moods changes, as being commonplace following a critical incident.

Most people are fairly resiliant, and in time, are able to muster the resources necessary to cope with such events and get on with their life. There are, however, some people who are either unable to cope with critical incident stress, or who have exhausted the resources they have, due to the continual or excessive demands on them to cope.

The need to provide assistance following serious and disturbing events, particularly in the workplace, has become increasingly recognised by those involved in emergency services (e.g. police, fire brigade, ambulance, medical response, rescue) hospitals, heavy industry, mining and energy industries, transport (trucking, airlines, bus and rail transport, taxi industry, shipping), financial institutions and other occupations where the potential to be confronted with a severely stressful event is ever present. In recent years, a constructive approach to this issue of helping others following a critical incident, has been the development of workplace *Peer Support Teams*.

What is a peer support team?

A peer support team is a collegial group, trained in appropriate methods of assisting those in their workplace who have been subjected to a critical incident. Teams of employee supporters have and are being established all around the country. The influence they have on preventing and reducing serious workplace trauma is being increasingly recognised.

Who is a peer supporter?

In most organisations peer supporters are volunteers who are trained in the primary role of providing support to others following a critical incident. They do this by simply being with them and allowing them to talk about their reactions, emotions and behaviours. In many situations, the peer supporter will be in a position to provide current information which assists the individual's coping process. Support may also include making sure any immediate physical needs are met, arranging contact with family members where appropriate, and organising transport home when required. As the name suggests, the employee supporter provides "support" only and does not become a counsellor, therapist, or take on any other role for which they are not trained or qualified.

HUTT VALLEY HEALTH

MENTAL HEALTH SERVICES

DEBRIEFING TEAM

CODE OF ETHICS

PRINCIPLES

1 Team members will hold information about those receiving support in confidence. Whilst upholding this principle, attention must be given to working within the constraints of the law.

2 Team members will ensure they make themselves reasonably available to those requiring support at the request of the team Co-Ordinator.

3 Team members will respond to individuals from a non-judgemental position, having respect for individual belief's and values.

4 Team Members will always work from a position of good will being honest and trustworthy in their interactions. At all times giving respect for each other's autonomy in their ability to make decisions for themselves.

DEBRIEFING FOLLOW UP QUESTIONNAIRE

UNIT:_____

Date of Incident: _____

Nature of Incident: _____

_____

_____

_____

_____

What support did you receive from the Debriefing Team?

1 Individual defusing session soon after the event. yes/no

2 Group defusing session soon after the event. yes/no

3 Individual session within 48 hours of event. yes/no

4 Group debriefing session within 48 hours of the event. yes/no

5 Follow up in the days/weeks following the event. yes/no

6 Any other peer support involvement (please specify):_____

_____

_____

_____

_____

What benefits did you notice from the support?_____

_____

_____

_____

_____

Was any aspect of intervention unhelpful? (Please give details):_____

_____

_____

_____

_____

What improvements would you like to see in the programme?

Any other feedback for the Debriefing Team?

Thankyou for your response.

Hutt Valley Health	Manual	CMH
	Doc No	
DEBRIEFING POLICY	Issue Date	February 1998
	Review Date	
	Written by	
	Approved	
	Page	1 of 5

PURPOSE:

To establish clear protocols for debriefing of critical incidents occurring in Hutt Valley Mental Health Services.

To ensure that effective debriefing of incidents benefits primarily the individual mental health practitioners, the community and the consumer.

To ensure that all staff are safe and cared for in a sensitive manner, mentally, physically and culturally.

To ensure medical, legal and ethical requirements are met.

POLICY
Scope:

Critical incident
- definition
- categories
- response

Initiation of Debriefing Procedure

Debriefing Team Training

Co-ordinator

Statistics

Definitions

Violence — The application of force, severe or serious abuse and includes:
- the use of physical force to injure,
- endanger or damage people or property
- intimidation, fear inducing behaviour or coercion
- verbal abuse and harassment of any kind

Staff/Health Professionals:

- any person employed to provide care or treatment to a client

Physical Restraint:

- an approved, skilled intervention by staff to prevent individuals from harming themselves, endangering others or seriously endanger the therapeutic environment.

AUTHORITY:

Hutt Valley Health Management Team.

CRITICAL INCIDENTS:

Critical incidents are any events that have sufficient emotional power to overcome the usual coping abilities of staff who are exposed to them.

Examples of critical incidents are:-

- sudden death of a client
- serious assault of a staff member
- serious assault of a client
- death of a staff member
- threat of injury/assault to staff or family
- self harm attempts including suicide, arson
- restraint either personal or mechanical
- homicide
- specific complaints against staff
- client accident involving injury
- sexual harassment, intimidation
- intruder activity or breach of security
- medical emergency

DEFUSING:

This is the support process that takes place as soon as possible after an event. The function of it, is to allow those involved with the incident to put the incident into a manageable perspective, and to help individuals cope more effectively with the pressures they may be feeling. Defusing are less formal and structured than a debriefing.

DEBRIEFING:

These are more structured group or individual meetings that are specifically designed to assist staff in managing uncomfortable thoughts, feelings and any other reactions to a critical incident. They are available to all staff who have a reaction to a critical incident. They are typically held within 24-72 hours after the event. Staff from supported accommodation and day services will be involved if appropriate.

DEBRIEFING TEAM:

This is a group of staff within the workplace who have been trained in appropriate methods of assisting colleagues who have been subjected to a critical incident at their work.

RESPONSE:

Hutt Valley Health Mental Health Services will provide 24 hour access to the peer support who will provide support and follow-up after an incident.

Supported accommodation and day service providers are able to access support from a member of the team.

All staff who have been involved in a critical incident, are to be informed of the availability of the debriefing team by the most senior staff member of the Unit on duty.

The request for debriefing is to be accessed through the team co-ordinator/team leader.

The Team Leader/co-ordinator will assign one or more debriefers to the incident from those available on duty.

Where necessary, debriefers who are not on duty but are available will be called upon.

ACCESS:

Each service will be provided with documentation to facilitate access to the co-ordinator and the debrief team.

A folder will be provided to each area of the service, containing information about the debrief team in the Mental Health Services of Hutt Valley Health.

An updated list of debriefers and how to access them will be available in each area.

TRAINING:

Debriefing team members will be trained by an independent trainer, ongoing training and supervision throughout the year.

Suitability for integration into the team will be assessed throughout the selection and training.

Team reviews to be held on monthly or bi-monthly basis.

CO-ORDINATOR:

A co-ordinator for the team will be appointed.

The co-ordinator will be responsible for the day to day running of the team.

The co-ordinator will keep records of the teams activities.

The co-ordinator will provide a summary statement of team activities to the Manager of Mental Health, Hutt Valley Health.

STATISTICS:

Activities of the team will be monitored in the form of reports and assessment forms completed by the debriefers, and the persons receiving the debriefings.

AUTHORITY:

Hutt Valley Health, Mental Health Service Manager.

Appendix B

Information for staff on strategies for Critical Incident stress support

HUTT VALLEY DHB

Information for staff
on strategies for

CRITICAL INCIDENT STRESS SUPPORT

Mental Health
Debriefing Team

Critical incident stress

Definition

Tragedies, deaths, serious injuries, hostage situations, threatening situations — these events are known as "critical incidents". People who respond to emergencies often encounter highly stressful events almost every day.

Sometimes an event is so traumatic or overwhelming that staff may experience significant stress reactions.

The Debriefing Team

Hutt Valley District Health Board has set up a special team specifically designed to support our staff in dealing with the occurrence, aftermath and stress of critical incidents.

The Critical Incident Stress Management Programme

This organised response to critical incident stress is an integrated system of interventions which is designed to minimise adverse psychological reactions.

Signs and symptoms of critical incident stress

How to recognise if you or a colleague are having critical incident stress

The chart on the opposite page lists a large number of signs and symptoms of critical incident stress. Not all of them — in fact perhaps only a few of them — may be outwardly visible or detectable, either by oneself or others.

Any of these symptoms may indicate the need for medical evaluation. If you or a colleage have had a critical incident, and aren't sure whether you're suffering critical incident stress, contact a member of the debriefing team, or, if the indications are acute, a doctor.

Critical incident stress: signs and symptoms

PHYSICAL	COGNITIVE	EMOTIONAL	BEHAVIOUR
Chills	Confusion	Fear	Withdrawal
Thirst	Nightmares	Guilt	Antisocial acts
Fatigue	Uncertainty	Grief	
Nausea	Hypervigilance	Panic	Inability to rest
Fainting	Suspiciousness	Denial	
Twitching	Intrusive images	Anxiety	Intensified pacing
Vomiting	Blaming someone	Agitation	
Dizziness	Poor problem solving	Irratibility	Loss or increase in appetite
Weakness	Poor abstract thinking	Depression	
Chest pain	Poor concentration or memory, disorientation of time, place or person	Intense anger	Change in usual communication
Headaches		Apprehension	Erratic movements
Elevated blood pressure		Emotional shock, etc.	
Rapid heart rate	Difficulty identifying objects or people; heightened or lowered alertness	Emotional outbursts	Change in social activity
Muscle tremors		Feeling overwhelmed	Changes in speech patterns
Grinding of teeth	Increased or decreased awareness of surroundings	Loss of emotional control	Hyperalertness to environment
Visual difficulties			
Profuse sweating		Inappropriate emotional response	
Difficulty breathing			

Things for you to try and consider yourself:

- Within the first 24-48 hours, periods of appropriate physical exercise and relaxation will alleviate some of the physical reactions.
- Keep busy.
- You are normal and are having normal reactions. Sometimes people can think they are going crazy.
- Talk to people — talk is the most healing medicine.
- Be aware of numbing the pain with overuse of drugs or alcohol.
- Reach out — people do care.
- Maintain as normal a schedule as possible.
- Spend time with others.
- Help your co-workers as much as possible by sharing feelings and checking out how they are doing.
- Give yourself permission to feel rotten and share your feelings with others.
- Some people find it useful to keep a journal of their thoughts and feelings.
- Do things that feel good to you.
- Don't make any big life changes.
- Do make as many daily decisions as possible which will give you a feeling of control over your life.
- Get plenty of rest.
- Reoccurring thoughts, dreams or flashbacks are normal — don't try to fight them — they'll decrease over time and become less painful.
- Try and eat well-balanced and regular meals

Critical incident stress: Supportive strategies for families and friends

Things other people may be able to do:

- Listen carefully.
- Spend time with the affected person.
- Offer assistance and a listening ear if they have not asked for help.
- Reassure them that they are safe.
- Help them with everyday tasks like cleaning, cooking, care for the family, minding children.
- Give them private time.
- Don't take their anger or other feelings personally.
- Don't tell them that they are "lucky it wasn't worse" — statements like these are not helpful.
- Instead, tell them that you are sorry such an event has occurred and that you want to understand and assist them.

Critical incident stress: A debriefing session

Sometimes it helps to discuss an incident with staff whose job it is to deal with such events.

This is a confidential meeting facilitated by trained debriefing staff, to help support people during their reactions following a critical incident.

Additional sessions are available if needed by the person.

Debriefing facilitators are (WHO OR HOW TO CONTACT) or Lesley Dee (Debriefing Team Coordinator), phone 570-9801

Critical Incident Stress: Individual Suport — Employer Assistance Programme

Sometimes people need more individual support with the on-going effects of a critical incident.

The Employer Assitance Programme (EAP) is a confidential programme where you can get some individual professional support *outside* Hutt Valley DHB. Counsellors are provided by Stratos, Ltd.

- *What will it cost me?*

  Hutt Valley DHB will pay for the first three visits. If further counselling is required you may be asked to meet all or part of the cost yourself. If that is difficult, you may discuss this with your counsellor.

- *Will anyone know why I am visiting the counsellor?*

  No, not unless you tell someone. The Programme is confidential.

- *How do I make an appointment with a counsellor?*

  Please telephone Katherine at Stratos, Ltd., on (04) 589-4858. *This is a confidential phone number.*

  OR —

  Obtain a current EAP Pamphlet from Occupational Health and Safety, phone (04) 566-6999 ext. 8686, or the Health Information Centre in the Hutt Hospital foyer.

Critical Incident Stress: More Information

For more information, contact —

The Debriefing Team
Community Mental Health Base
Hutt Valley District Health Board
Private Bag 31907, Lower Hutt

Critical Incident Stress: References to Support Self-help

Getting A Good Nights Sleep
Fiona Johnston
Tandem Press,1998.

How To Manage The Stress Of Traumatic Incidents. A guide for police, ambulance, fire, rescue and emergency medical personnel
Michael Tonnecliffe
Bayside Books,1995

The Anger Workbook
Lorraine Blodeau
Hazelden Educational Materials 1992

The Less Stress Book. How To Turn Stress To Your Advantage. A Consumers Institute Guide
David Winsborough & Kay Alle
Consumers Institute of NZ Inc, 1997

The Relaxation & Stress Reduction Workbook
Martha Davis, Elizabeth Robbins, E. Shelman, Mathew Mckay
New Harbinger Publications Inc. 1998

Thoughts & Feelings
Mathew Mckay, Martha Davis, Patrick Fanning
New Harbinger Publications Inc 1997

Hutt Valley District Health Board
High Street — Private Bag 31907
Lower Hutt, New Zealand
Telephone 04-566-6999
Facsimile – Hospital 04-570-4401
Facsimile – Administration 04-570-4424

Appendix C

Hutt Valley Health company policy manual for Critical Incident Stress Management

Hutt Valley Health	Manual	Company Policy Manual
	Doc No	RMC2-Debrief
Critical Incident Stress Management (Debriefing)	Issue Date	October 2000
	Review Date	October 2002
	Written by	Risk Management
	Approved	CEO
	Page	1 of 3

PURPOSE

To provide a process to support staff involved in an incident and to reduce recovery time from a stressful experience by restoring staff to normal functional efficiency.

POLICY

Definition

A critical incident is any event having enough impact to overwhelm the usually effective coping skills of an individual or group; causing them to experience unusually strong emotional reactions having the potential to interfere with their ability to function at the time of the event or sometime later.

Critical incidents can arise from both major incidents (e.g. disasters) or from routine work activities (e.g. health settings). Any incident has the potential to affect a worker, it does not have to be a major disaster.

Examples

- death of a child or caring for severely sick or seriously injured child
- death or serious injury to colleague in the line of duty - workplace accident
- caring for a person who is a relative or close friend, who is dying or in very serious condition
- suicide or attempted suicide of colleague or client/patient
- personal threat from very violent person - hold-up or hostage situation
- serious multiple casualty incident
- disaster

PROCEDURE

Immediate Management of Critical Incidents.

The immediate management of a Critical Incident should be undertaken by the Service Manager of the unit involved in consultation with appropriate personnel. Where possible management should maintain an overview strategy and the Manager should delegate tasks rather than becoming personally involved. Assistance may be

requested from the Risk Advisor and/or Occupational Health and Safety Team. The Service Manager has responsibility for full documentation of the incident and reporting to the Chief Executive Officer.

Full support must be given to front line staff both during the incident and in the aftermath.

Critical Incident Stress Debriefing.

Defusion

Depending on the incident it may be necessary to defuse immediately, and hold a more formal debrief after 48 hours or up to seven days. Defusion deals with the initial problems faced by victims and then allows time to consider the situation and be more able to discuss it.

Defusion should be held after staff have been disengaged from operations and held within eight hours of the incident. Occupational Health Team and Mental Health professionals should be involved if possible. At the least, a manager should ensure that staff have had an opportunity to talk together about the incident before going home and are safe to go home and are supported.

Psychological Debriefing

Psychological debriefing can be an individual or group process concerned with staff reactions to an event and their ways of coping with it. Debriefings are intended to facilitate discussion of what happened, how the event generated the unusual set of symptoms (both during and after the event), to assist victims to understand that their reactions are normal and to assist them to understand the event and its consequences.

The goals of stress debriefing are:

- supporting staff
- helping them to adapt to their experience
- protecting them from developing entrenched reactions.

WHEN Up to seven days after the incident

WHERE Comfortable, easily accessible venue removed from the work environment. Refreshments and tissues should be available.

WHO Use of outside counsellor is recommended as they are objective and can be seen as such. (EAP contractor can arrange suitable person) Hutt Valley Health Mental Health Service has some trained counsellors who could be of assistance if available. The assistance of senior psychiatric staff is also an advantage.

HOW Ensure those running the sessions have the appropriate skill levels Confidentiality of sessions must be stressed and any recommendations from participants should be followed up.

Operational Debriefing

A debriefing about operational matters (performance issues, mechanical aspects, identifying training needs, equipment needs/failure etc.) should always be conducted by a senior member of the staff and recommendations for changes to procedure followed up.

REFERENCE

Psychological Aspects of Disasters Edited by Douglas Paton and Nigel Long

Appendix D

Hutt Valley Health mental health service policy manual for Critical Incident Debriefing

PURPOSE

To provide a professional service that supports and minimises stress for HV DHB staff involved in a critical incident related to HV DHB operations.

The primary focus of this policy is HV DHB staff however HV DHB also recognises its reposnsibility to ensure other persons involved in, or affected by a critical incident related to HV DHB operations are provided with adequate defusion and debriefing should this be indicated.

POLICY

Definitions

A **critical incident** is any event having enough impact to overwhelm the usually effective coping skills of an individual or group; causing them to experience unusually strong emotional reactions having the potential to interfere with their ability to function at the time of the event or some time later.
Critical incidents can arise from both major incidents (e.g. disasters) or from routine work activities (e.g. Health settings). Any incident has the potential to affect a staff member, it does not have to be a major diisaster.

Examples of critical incidents are:-

- sudden death of a client
- serious assault of a staff member
- serious assault of a client
- death of a staff member
- threat of injury/assault to staff or family
- self harm attempts including suicide, arson
- restraint either personal or mechanical
- homicide
- specific complaints against staff
- client accident involving injury

- sexual harassment, intimidation
- intruder activity or breach of security
- medical emergency

PROCEDURE

Immediate Management of Critical Incidents

- The immediate management of critical incidents must be undertaken by the most senior staff member of the Service/Unit on duty, in consultation with appropriate personnel. Assisstance may be requested from the Risk Advisor and/or Occupational Health and Safety Team.
- All HV DHB staff (and other persons) who have been involved in a critical incident, are to be informed of defusion and debriefing procedures.
- The Service Manager must be informed and has full responsibility for ensuring full documentation of the incident and reporting to the Chief Executive Officer.

CRITICAL INCIDENT STRESS BEBRIEFING

DEFUSING

This is the support process that takes place as soon as possible after an event. The function of defusing, is to allow those involved with the incident to put the incident into a manageable perspective, and to help individuals cope more effectively with stresful feelings related to the incident. Defusing is less formal and structured than a debriefing and should occur within eight hours of the incident.
The Line Manager or most senior staff member of the Service/Unit on duty must ensure staff have had the opportunity to talk together about the incident before going home, are safe to go home and are supported..
Occupational Health Team and Mental Health professionals may be involved if appropriate.

DEBRIEFING

The goals of stress debriefing are:

- Supporting staff
- Helping then to adapt to their experience
- Protecting them from developing entrenched rreactions

These are more structured group or individual meetings that are specifically designed to assist staff in managing uncomfortable thoughts, feelings and any other reactions to a critical incident. They are available to all staff who have a reaction to a critical incident.

WHEN Up to 7 days after the incident

WHERE Comfortable, private, easily accessible venue removed from the direct work environment.

WHO Approved debriefing facilitators must conduct the formal debriefing sessions. HV DHB Mental Health Service have a Debriefing Co-ordinator who has a list of trained debriefers availabel 24 hours. This is a group of HV DHB staff who have been trained in appropriate methods of assisting colleagues who have been subjected to a critical incident at their work. The assistance of senior psychiatric staff is also available.

An external debriefer may be arranged through HV DHB OSH Clinic.

Other persons (non HV DHB staff) involved in or affected by the incident
The Line Manager or most senior staff member of the Service/Unit on duty is responsible for ensuring that other persons (non HV DHB staff) involved in, or affected by the incident are provided with access to defusion and where required debriefing meetings separate to staff. An HV DHB Debriefing team member must facilitate these meetings.

ACCESS FOR DEBRIEFING REQUESTS:

8am – 5pm Weekdays: Phone Lesley Dee CMHTeal Leader 570-9839 leave a message .
For General Hospital requests for debriefing - contact Toni Dal Din through HV DHB Operator.
See attached Flow Charts

TRAINING

Debriefing team members will be trained by an independent trainer, ongoing training and supervision throughout the year.

Suitability for integration into the team will be assessed throughout the selection and training.

Debriefing Team reviews to be held on monthly or bi-monthly basis.

CO-ORDINATOR

A nominated staff member will be appointed as Debriefing Co-ordinator

The co-ordinator will be responsible for the day to day running of the team.

The co-ordinator will keep records of the teams activities.

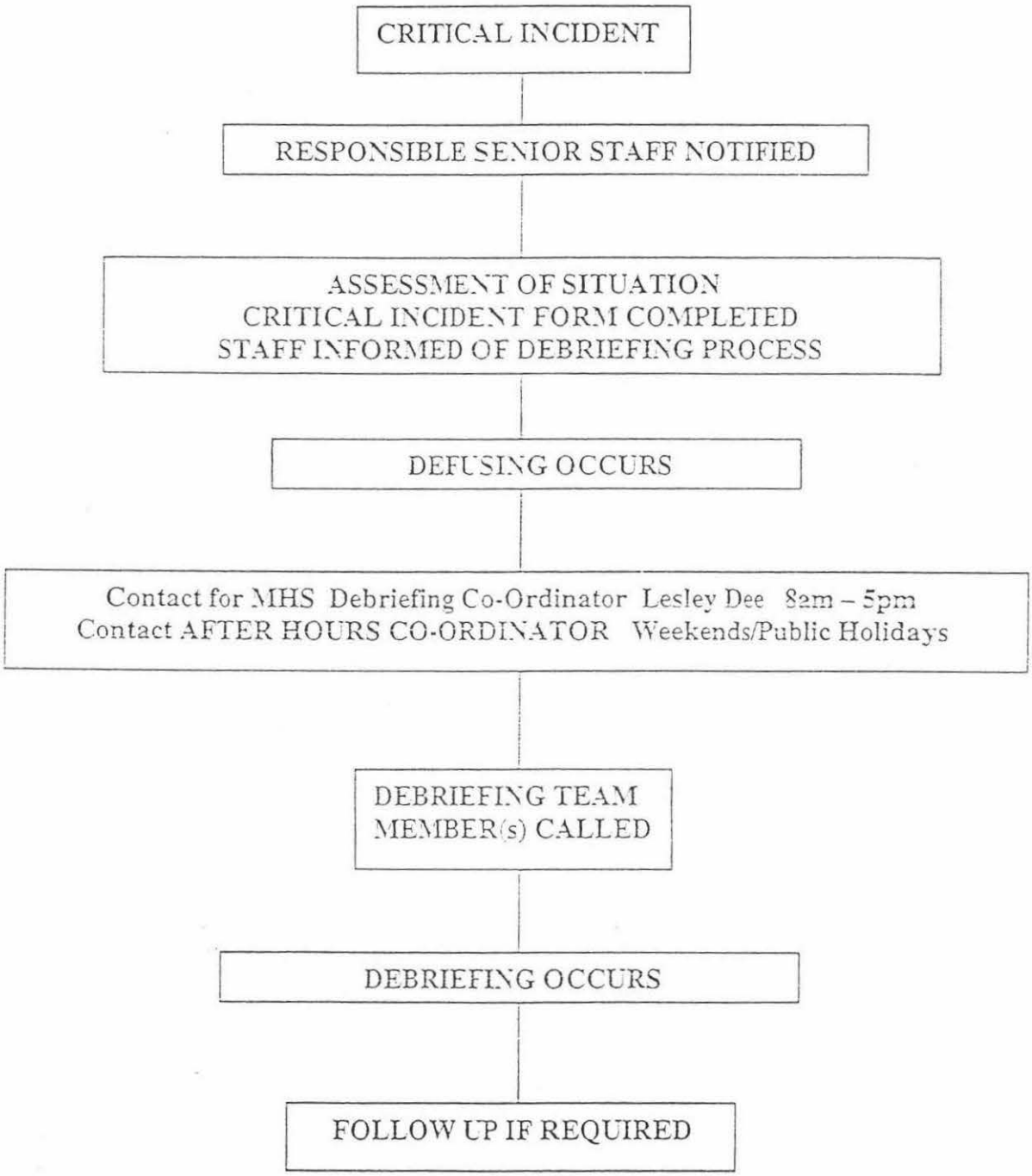
The co-ordinator will provide a summary statement of team activities to the Service Manager of Mental Health, Hutt Valley DHB.

STATISTICS

Activities of the team will be monitored in the form of reports and assessment forms completed by the debriefers, and the persons receiving the debriefings.

AUTHORITY

Hutt Valley DHB, Mental Health Service Manager.


CRITICAL INCIDENT
RESPONSIBLE SENIOR STAFF NOTIFIED
ASSESSMENT OF SITUATION
CRITICAL INCIDENT FORM COMPLETED
STAFF INFORMED OF DEBRIEFING PROCESS
DEFUSING OCCURS
Contact for MHS Debriefing Co-Ordinator Lesley Dee 8am – 5pm
Contact AFTER HOURS CO-ORDINATOR Weekends/Public Holidays
DEBRIEFING TEAM MEMBER(s) CALLED
DEBRIEFING OCCURS
FOLLOW UP IF REQUIRED

Appendix E

Critical Incident Debriefing questionnaire

Critical Incident Debriefing Questionnaire

This questionnaire is about the Debriefing Programme currently in place at Te Whare Ahuru. This is your chance to anonymously express how you feel about the programme and any critical incidents you have been involved in.

A **critical incident** is any event that has a stressful impact. Critical incidents are typically, sudden or frightening events that are outside of the range of ordinary human experiences. They can have a strong emotional effect, even on well-trained, experienced people.

Please read all instructions for each set of questions carefully, as they are not all the same.

Your first answer is usually the best one. Please do not take long answering each question as this questionnaire should only take you about 15 minutes to complete. Completion of this questionnaire implies your consent.

Thank you for your time.

DESCRIPTIVE INFORMATION

Please base all your responses in this questionnaire on the most recent Critical Incident you have been involved in at Te Whare Ahuru.

1. Briefly describe the most recent critical incident you were involved in?

.....

.....

2. How long has it been since the critical incident above occurred? (Circle one)

Less than 1 month ago 1-3 months ago 3-6 months ago Longer than 6 months

3. Did you have the opportunity to attend a debriefing session following this incident?

.....

4. Did you attend the debriefing session if it was offered?

.....

5. If you did not attend the debriefing session for this critical incident please explain why.

.....

.....

6. Have you had any ongoing debriefing or other counselling following this incident?

.....

7.How many critical incidents have you been involved in at Te Whare Ahuru?

.....

8. How many debriefings have you received at Te Whare Ahuru?

.....

9. How did you find out about the debriefing programme? (Circle one)

I don't know about it My supervisor Written information Other (please explain)

.....

ATTITUDES TO DEBRIEFING

We would like you to answer some questions about the debriefing service at Te Whare Ahuru. We are interested in your honest opinion, whether positive or negative. Please read each section carefully and answer all the questions.

		Very True for me	Somewhat True for me	I Don't Know	Somewhat Untrue for me	Very Untrue for me
1	I know what a debriefing session involves.....	1	2	3	4	5
2	The information given to me about what the debriefing programme involves was satisfactory.....	1	2	3	4	5
3	I know how to get a debriefing, if I need one, after a critical incident.....	1	2	3	4	5
4	I have had to ask for a debriefing for myself	1	2	3	4	5
5	I have attended every debriefing session that has been offered to me .. .	1	2	3	4	5
6	I know there is a person I can contact at Te Whare Ahuru, if I want to talk to someone after the debriefing session is finished.....	1	2	3	4	5
7	I believe debriefing programmes have no place at Te Whare Ahuru.....	1	2	3	4	5
8	I would rather deal with the emotions I experience from a critical incident, on my own, and not in a debriefing session.....	1	2	3	4	5

Please answer the following if you've been to a debriefing. If not, please continue to page 5

		Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
1	The debriefing session made me feel better.....	1	2	3	4	5
2	It was a waste of my time to attend the debriefing session.....	1	2	3	4	5
3	The debriefing session was given too soon after the critical incident I was involved in	1	2	3	4	5
4	Attendance at the debriefing session was encouraged.....	1	2	3	4	5

		Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
5	The debriefing session made me feel uncomfortable.	1	2	3	4	5
6	I felt worse after the debriefing session.	1	2	3	4	5
7	The debriefing session was well run by the debriefing team.	1	2	3	4	5
8	I found the debriefers to be intrusive...	1	2	3	4	5
9	The debriefers were sympathetic.....	1	2	3	4	5
10	I felt pressured to talk in the debriefing session.	1	2	3	4	5
11	The debriefers helped make people feel at ease.....	1	2	3	4	5
12	I would choose to attend another debriefing session if I was involved in a critical incident again.....	1	2	3	4	5
13	I do not like expressing my thoughts and feelings in front of others.....	1	2	3	4	5
14	I believe a professional needs to be available for the staff at Te Whare Ahuru, after a debriefing session is finished, in case they want to talk in private.....	1	2	3	4	5

IMPACT OF EVENTS

DIRECTIONS: The following is a list of difficulties people sometimes have after stressful life events. Please read each item, and circle the response that reflects **how distressing** each difficulty has been for you **during the last seven days.** The questions refer to the critical incident that you have chosen for this questionnaire.

		Not At All Distressing	A Little Bit Distressing	Moderately Distressing	Quite A Bit Distressing	Extremely Distressing
1	Any reminder brought back feelings about it.....	0	1	2	3	4
2	I had trouble staying asleep.....	0	1	2	3	4
3	Other things kept making me think about it.....	0	1	2	3	4
4	I felt irritable and angry.....	0	1	2	3	4
5	I avoided letting myself get upset when I thought about it or was reminded of it.....	0	1	2	3	4
6	I thought about it when I didn't mean to.....	0	1	2	3	4
7	I felt as if it hadn't happened or wasn't real.....	0	1	2	3	4
8	I stayed away from reminders about it.	0	1	2	3	4
9	Pictures about it popped into my mind.....	0	1	2	3	4
10	I was jumpy and easily startled.....	0	1	2	3	4
11	I tried not to think about it...	0	1	2	3	4
12	I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13	My feelings about it were kind of numb.....	0	1	2	3	4
14	I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15	I had trouble falling asleep.	0	1	2	3	4
16	I had waves of strong feelings about it.....	0	1	2	3	4

		Not At All Distressing	A Little Bit Distressing	Moderately Distressing	Quite A Bit Distressing	Extremely Distressing
17	I tried to remove it from my memory.	0	1	2	3	4
18	I had trouble concentrating.	0	1	2	3	4
19	Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20	I had dreams about it.	0	1	2	3	4
21	I felt watchful and on guard.	0	1	2	3	4
22	I tried not to talk about it.....	0	1	2	3	4

HEALTH CHECKLIST

DIRECTIONS: Now, we would like to know how you have been feeling over **the past seven days**, including today. Below is a list of experiences that you may have been feeling over this time. Please circle the appropriate number to describe **how distressing** you have found these experiences over this time.

		Not At All Distressing	A Little Bit Distressing	Moderately Distressing	Quite A Bit Distressing	Extremely Distressing
1	Difficulty in speaking when you are excited.	1	2	3	4	5
2	Trouble remembering things.....	1	2	3	4	5
3	Worried about sloppiness or carelessness.	1	2	3	4	5
4	Blaming yourself for things.....	1	2	3	4	5
5	Pains in the lower part of your back.....	1	2	3	4	5
6	Feeling lonely.	1	2	3	4	5
7	Feeling blue.....	1	2	3	4	5
8	Your feelings being easily hurt.	1	2	3	4	5
9	Feeling others do not understand you or are unsympathetic.	1	2	3	4	5

		Not At All Distressing	A Little Bit Distressing	Moderately Distressing	Quite A Bit Distressing	Extremely Distressing
10	Feeling that people are unfriendly or dislike you...	1	2	3	4	5
11	Having to do things very slowly in order to be sure you are doing them right.	1	2	3	4	5
12	Feeling inferior to others .	1	2	3	4	5
13	Soreness of your muscles.	1	2	3	4	5
14	Having to check and double check what you do.	1	2	3	4	5
15	Hot or cold spells.....	1	2	3	4	5
16	Your mind going blank. ...	1	2	3	4	5
17	Numbness or tingling in parts of your body.	1	2	3	4	5
18	A lump in your throat.....	1	2	3	4	5
19	Trouble concentrating.	1	2	3	4	5
20	Weakness in parts of your body.....	1	2	3	4	5
21	Heavy feelings in your arms and legs.....	1	2	3	4	5

GENERAL HEALTH

DIRECTIONS: Please state how you would rate your health at the present time. Circle the most appropriate response.

Excellent Good Average/OK Poor Terrible

OVERALL JOB SATISFACTION

DIRECTIONS: Please circle how satisfied or dissatisfied you are with the following aspects of your job, using the following categories.

		Extremely Dissatisfied	Moderately Dissatisfied	Not Sure	Moderately Satisfied	Extremely Satisfied
1	The physical work conditions	1	2	3	4	5
2	The freedom to choose your own work method.....	1	2	3	4	5
3	Your fellow workers.....	1	2	3	4	5
4	The recognition you get for good work.....	1	2	3	4	5
5	Your immediate supervisor.	1	2	3	4	5
6	The amount of responsibility you are given.	1	2	3	4	5
7	Your rate of pay.....	1	2	3	4	5
8	Your opportunity to use your abilities.	1	2	3	4	5
9	Industrial relations between management and workers.	1	2	3	4	5
10	Your chance of promotion.	1	2	3	4	5
11	The way your organisation is managed.....	1	2	3	4	5
12	The attention paid to suggestions you make	1	2	3	4	5
13	Your hours of work.....	1	2	3	4	5
14	The amount of variety in your job.	1	2	3	4	5
15	Your job security.	1	2	3	4	5

DEMOGRAPHIC INFORMATION

Please provide us with some information about yourself for comparison purposes. Remember that this questionnaire is anonymous.

Your Age in years _____

Please circle the most appropriate response:

Gender: Male Female

Your Ethnic Group: NZ European NZ Maori Pacific Island

State if other _____

How much sick leave have you taken in the last six months?

1-7 days 7-14 days 14-21 days More than 21days

How many years experience do you have working in the mental health field?

1-5 years 5-10 years 10-20 years More than 20 years

THANK YOU FOR YOUR TIME IN PROVIDING VALUABLE RESPONSES TO THIS QUESTIONNAIRE.

PLEASE RETURN THE QUESTIONNAIRE TO THE BOX PROVIDED

Appendix F

Information sheet for participants

Massey University
COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Psychology
Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 350 5673

Information Sheet

Principal Investigator:
Ms Sharon Leadbetter
Masters Student
School of Psychology
Massey University
Private Bag 11 222
Palmerston North

You are invited to take part in a study that will look at the effectiveness of debriefing at this mental health unit. You can choose whether or not to take part, and can take as long as you wish to decide. The researchers of this study are Sharon Leadbetter, a Masters student, and her supervisor, Dr Christine Stephens, a lecturer from the School of Psychology at Massey University. You can contact the researchers by writing to the address above, or by telephoning on 06 350 5999 extn 2071.

What is the study about?
The aims of this study are to understand how effective the introduction of the Critical Incident Debriefing programme has been to this mental health unit, and how knowledgeable staff are about this programme.

Who is being approached?
We are seeking the participation of all the staff of this mental health unit. This will enable us to gain an understanding of how the debriefing programme has affected each staff member and what issues are important and relevant to the successful use of this programme.

All that is required of the participants of this study is to fill out an anonymous questionnaire, which will take about 15 minutes to complete. The questionnaire will be presented and explained to the staff by the principal researcher Sharon Leadbetter, at the staff handover shift meeting. The information provided will be used as a baseline (initial evaluation) for a long term study on Critical Incident Debriefing. Upon completion of the questionnaire, participants may either return them to a sealed box at the mental health unit, which the researcher will take with her at the end of the day or send it to the researcher in the freepost envelope provided. Completion of this questionnaire implies your consent.

What will happen to the information?
The data will only be seen by the researchers of this study. For the duration of the study, the anonymous questionnaire data will be kept in a locked cabinet. After the study is completed, the anonymous questionnaire data will be transferred back to Te Whare Ahuru. This is for potential use in their longitudinal research on the debriefing programme. Material that could personally identify you will not be used in any reports on this study.

What can the participants expect?
Participation is entirely voluntary; it is your choice. You do not have to take part in this study. If you choose not to take part, this will not affect your employment. If you do participate, you are free to withdraw or stop any time up to handing in the questionnaire to the researchers. You can not withdraw after this point because the questionnaires are anonymous and it would not be possible to identify which one was your questionnaire. You do not have to give a reason for withdrawing, and this will in no way affect your employment. You do not have to answer all the questions on the questionnaire.

We hope that staff will benefit from expressing their knowledge and opinions in more detail than usual. Discussing some issues may prove upsetting and if this happens, you can pause or stop filling out the questionnaire. If there is continuing distress, an outside support person is available for any confidential consultation. A pamphlet with more information and contact details will be handed out with the questionnaires.

In broader terms, staff may benefit from the knowledge that they are helping to develop an understanding of the effectiveness of this debriefing programme and its affects on its recipients. Once the study is completed early next year, copies of a summary sheet of the research results will be made available at the staff handover shifts. Extra copies could also be obtained by contacting the researchers of this study at Massey University, at the address overleaf.

Where can I get further information?
This study has received ethical approval from the Massey University Human Ethics Committee and the Wellington Ethics Committee. The Service Manager of this mental health unit has also given permission for this study to be carried out.

If you have any questions about the study in general, please feel free to contact Ms Leadbetter, whose address and telephone number are provided at the beginning of this information sheet.

Thank you for your time.

Sharon Leadbetter

Appendix G

Employee assistance programme leaflet

Personal Problems the Employee Assistance Programme can help with:

- relationship difficulties
- family troubles
- depression & anxiety
- physical & mental ill-health
- money worries
- legal issues
- abuse & addiction problems
- alcohol & drug problems
- stress

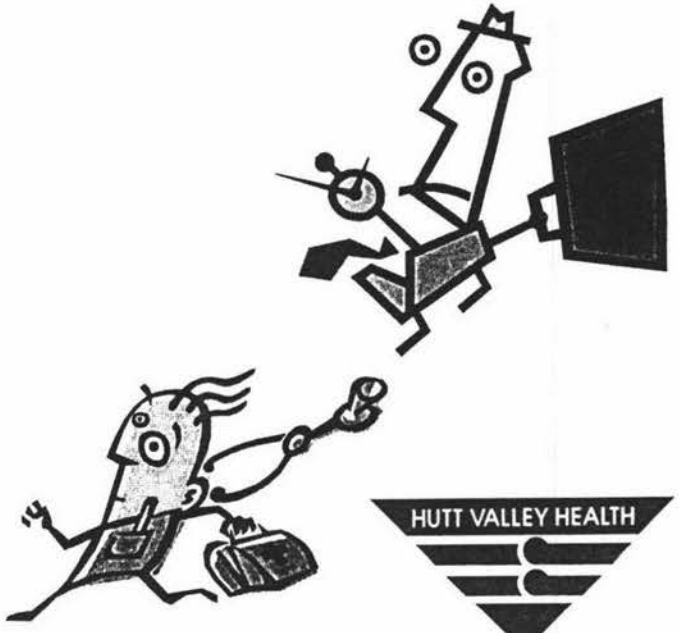
For further information please phone this *confidential* telephone number for information about the Employee Assistance Programme (04) 589 4858

This service is provided for you by Hutt Valley Health Corporation Limited

Employee

Assistance

Programme



HUTT VALLEY HEALTH

Important information about the Employee Assistance Programme (E.A.P.)

What is the E.A.P?
It is a free confidential counselling service provided by Hutt Valley Health to all its staff.

Who can use the Programme?
Any employee of Hutt Valley Health Corporation.

Do I have to use the Programme if I don't want to?
No, the counselling is entirely voluntary.

What will it cost me?
Hutt Valley Health will pay for the first three visits. If further counselling is required you may be asked to meet all or part of the cost yourself. If that is difficult, please discuss this with your counsellor.

How do I use the E.A.P?
Telephone one of the counsellors named on the opposite page and arrange a suitable time and place to meet.

Will anyone know why I am visiting the counsellor?
No, not unless you tell someone. The Programme is totally confidential. No confidential information will go back to your work area without your written consent.

What happens when I go to see the counsellor?
You will discuss the difficulties you are experiencing and together with the counsellor look at ways of resolving them. If the counsellor believes someone else would be more able to help you, s/he will recommend a suitable person.

Will my manager know I'm using the E.A.P?
No one will know if you've used the Programme. However, if your work is below standard, your manager may suggest you use the Programme.

How do I make an appointment with a counsellor?
- ✓ select a counsellor from the next page
- ✓ say that you work for Hutt Valley Health
- ✓ leave your name and a telephone number
- ✓ say when is the best time to phone you

This E.A.P. has been available to staff since 1991. Hutt Valley Health contracts Stratos Limited (an independent external provider) to ensure all staff have access to professional competent counsellors.

The Stratos Counsellors are:

Gordon Hewiit -	562-7101 / 499-3541
Geraldine Lakeland -	499-3541
Jennifer O'Connell	472-0710
Colin Haynes -	471-0779
Suzanne Johnson -	499-1955

Sue Young -	566-1144
Jane Dyne	566-4078
Elizabeth Money	566-4078
Mary Jarmulski	384-8275
Annie Rogers -	499-3541

These people are not members of Hutt Valley Health Corporation staff. They are contracted to Stratos Limited to provide professional counselling to employees of Hutt Valley Health.

The counsellors are committed to confidentiality and will not give any information to any Hutt Valley Health management or staff.

If there are any matters you wish to discuss prior to deciding about counselling, please telephone the Stratos Limited manager, Ann Tucker, or Yvonne, her secretary (tel: 04 589 4858, mobile: 021 450 242).

Appendix H

Cover letter to participants who were not at the staff handover shift meetings

School of Psychology
Massey University
Private Bag 11 222
Palmerston North

15 December 2000

Dear Te Whare Ahuru Staff Member,

I am sorry to have missed you today as over the last week I have been handing out my questionnaire to the staff at Te Whare Ahuru. I am evaluating the debriefing programme currently in place for this small staff and it is important to get the views of everyone, which is why I am sending this to you personally. Your opinion about your debriefing programme is very important.

Please find enclosed a copy of my information sheet, questionnaire, and a freepost envelope to return them in. I would really appreciate you taking 10-15 minutes of your time to read the information sheet about my thesis and complete the questionnaire.

If you have any questions, my details are on the information sheet enclosed.

I would really appreciate your help with my research.

Yours sincerely

Sharon Leadbetter

Appendix I

Reminder notice to participants

Massey University
COLLEGE OF HUMANITIES & SOCIAL SCIENCES

School of Psychology
Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 350 5673

19 December 2000

Psychology Department
Massey University
Private Bag 11 222
Palmerston North

To Current and Former Employees of Te Whare Ahuru,

REMINDER NOTICE

Thank you to those who have filled out my questionnaire, I appreciate you taking the time to do it. For those of you who may not have completed the questionnaire yet, can I please encourage you to do so, as soon as you can. The sample size for my research is quite small, as I am only evaluating the debriefing programme at Te Whare Ahuru, so every response is important to me. Your response also helps ensure the information I collect is meaningful.

Thank you for your help.

Yours sincerely

Sharon Leadbetter
Masters Student