Arriva Trains Wales (ATW) – new approach to addressing stress disorders caused by traumatic incidents

Introduction

It is widely recognised that railway staff involved in fatalities and other traumatic incidents are at risk of developing stress or anxiety reactions. Research[1] suggests that "Person under Train" incidents are the primary cause of Post-Traumatic Stress Disorder (PTSD) in the rail industry.

PTSD is a recognised and definite mental disorder. The American Psychiatric Association's Diagnostic and Statistical Manual defines PTSD as:

"the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves 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".

Additionally, at the time: *"The person's response to the event must involve intense fear, helplessness, or horror. The characteristic symptoms resulting from the exposure to the extreme trauma include persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal. The full symptom picture must be present for more than 1 month, and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning".*

Malt et al (1993) determined the incidence rate for PTSD following railroad accidents in Norway and Sweden as being greater than 50% after one month post-accident. A separate study by Farmer et al., (1992) examined the reactions of 76 London Underground drivers who experienced persons jumping or falling in front of trains. They determined that one month after the incident, 17 percent of the drivers had PTSD but 31% had a separate but definite psychiatric diagnosis (Farmer R, Tranah T, O'Donnell I, *et al, 1992)*

Arriva Trains Wales (ATW) has adopted an innovative approach to address such stress reactions and assist its employees in reaching a healthy

[1] Health and Safety Laboratory Review HSL/2004/16, cited by Professor Paul Rogers of the University of Glamorgan, for Arriva Trains Wales

conclusion to such episodes. In particular ATW has moved away from traditional rail industry approaches and moved to Trauma-Focussed Cognitive Behavioural Therapy (T-F CBT), and Eye Movement Desensitisation and Reprocessing (EMDR) as recommended by the National Institute of Clinical Excellence (NICE); a body responsible for determining what treatments work for what health conditions.

Welfare meetings with ATW drivers had indicated some dissatisfaction and lack of consistency in the support provided following an operational fatality. This prompted ATW to carry out research to review its existing Chain of Care and support procedures. Employees who had experienced problems were invited to participate, and were interviewed, as were a number of line managers, as it was recognised that support for managers was weak. ATW sought external input to this project, including Professor Paul Rogers, an expert in PTSD, who works also with the emergency services and Prison Service, and Andrew Taylor from the Workforce Development Team at RSSB, who also worked with us, as part of a placement with ATW. All of this work has resulted in the introduction of revised procedures for managing post incident stress.

ATW's revised policy and procedures for trauma management

ATW's post incident stress policy commits to supporting employees (including temporary or fixed term staff) involved in a traumatic event at work. The commitment extends to those, including managers, attending the scene of such an incident or who may otherwise be affected through their dealings with traumatised persons. Our new policy and practice moves away from the industry standard provision of counselling in such cases. NICE has concluded, since HSL's 2004 literature review recommending a counselling approach, that counselling is actually ineffective in addressing PTSD. Recognising the timescale differences between Acute Stress Disorder and PTSD, our company policy is to not clinically intervene within 28 days post incident, in accordance with NICE guidelines. The policy sets firm and clear timescales for referral to Occupational Health initial assessment and thereafter to specialist support.

During the first 27 days after an incident, ATW policy is to adopt a position of "watchful waiting". Only if co-morbid conditions emerge such as depression, panic attacks or suicidal thoughts would we expect line management intervention during this period. In such a case the individual would be urged to visit their GP for immediate medical support.

ATW recognises that counselling, group therapy, relaxation, hypnosis and psycho-analytical techniques have not been shown to be effective in the treatment of post incident stress and, in accordance with NICE guidelines 2005, will not deploy these techniques in cases of post-traumatic incident stress.

Where symptoms are still being experienced more than 28 days after the incident, it may indicate that PTSD is likely to be present. The employee is then directly referred by our occupational health provider for an assessment to establish whether Trauma Focussed Cognitive Behavioural Therapy (T-F CBT) or Eye Movement Desensitisation and Reprocessing (EMDR) is appropriate. Our policy provides for an affected employee's partner or other nearest relative to be seen with the employee's consent to help them understand post-traumatic stress, associated conditions and their treatment, and how they may support the affected person. Our policy makes provision for authorisation of continuing pay based on average earnings during absence, to alleviate financial worries which would potentially induce further stress.

At the end of the treatment, of up to 12 weeks of sessions, a return to work plan will be incorporated in the specialist's assessment report. This may for example include a programme of phased re-introduction to the driving environment, initially using the ATW train simulator facility, before returning to experience the cab with a driver instructor on the route, and ultimately returning to driving duties.

ATW is also considering developing a "buddy" support network for those experiencing difficulties arising from incident trauma, following an example pioneered by London Underground Limited.

Competences

Managers are currently being trained in the new developments of ATW policy and procedures relating to traumatic incident stress.

The syllabus for the 3 hour managers' workshop includes:

- The nature of PTSD and anxiety disorders, risk factors and treatments (delivered by Professor Rogers);
- A personal account of the experience of a driver and their treatment with Trauma Focussed CBT;
- The new Arriva policy and procedures including:
    - Immediate trauma scene support and management;
    - Support and management of individuals in the first 4 weeks post incident;
    - The role of the company's occupational health provider;
    - The role of external independent providers of trauma focussed cognitive behavioural therapy

ATW is currently compiling a register of those persons professionally competent and accredited to deliver Trauma Focussed Cognitive Behavioural Therapy throughout the company.

Information to Employees

"Chain of Care Leaflet for Employees Exposed to Trauma at Work"

This leaflet helpfully outlines the normal reactions to traumatic events, and provides advice on addressing certain behaviours that may be manifested.

Information to Managers

"Chain of Care Leaflet for Managers whose Employee Has Experienced Trauma"

This summarises the normal reactions to traumatic events, and the resources available to support the employee and, as importantly, the manager. The leaflet outlines the possible symptoms of both Acute Stress Disorder and of PTSD and the timescales relevant in distinguishing the two.

New guidance for managers on the 'Do's and Don'ts of trauma management is reproduced at the end of this case study.

Benefits of the revised approach to trauma management

Although we are still in the early stages of embedding this new approach, feedback from affected staff and also managers has been very positive. Those individuals who have received support under both the old and the new trauma management procedures have indicated that the new approach is far better and has allowed them to recover sooner. Although not formally evaluated at this time, we estimate that approximately 80-90% make a full recovery after 12 sessions. We are working on ways of more formally assessing the impact of the new system by comparing the duration on Chain of Care prior to and since the introduction of T-F CBT/EDMR.

This new approach has been before the ASLEF Executive Committee. They have fully endorsed it and sent it to all Passenger and Freight TOCs as best practice and something to work towards.

Manager's Do's and Don't Guidance for Managers

The following guidance is provided to Managers when dealing with traumatised staff when called out to the trauma scene and also for the 3-4 weeks thereafter; until the employee has a PTH / Trauma Focussed CBT (TF-CBT) assessment / treatment plan.

This is only guidance and the Manager must "call it as they see it" at the time using professional judgement to assist them. One of the most important things to bear in mind is that there is no "one size fits all" approach for everyone and every trauma. Different people respond differently, indeed the same person may respond differently if it is their 2nd trauma experience. The general rule of thumb is to ask the person what they think would help them. If they cannot answer such an open question due to concentration difficulties / high levels of distress then it can be a good idea to offer them options to choose from (i.e., would you prefer I drop your home or prefer someone comes to collect you (and your car); would you prefer I call around in the morning or afternoon? What time would be best? etc). The person is likely to feel as if the normal rules of life have been "broken", so assisting them to make decisions through either open ended - or forced choice / closed questions can be helpful. Anything that helps the person "feel more in control" is a good idea.

Further do's and don'ts include:

Do's	Avoid
Be yourself, take your time – don't rush decisions despite the pressures on you	Being pressurised into putting the functional status of the railway first
Put the employees situation and health as high on your priority list; as high as the investigation / returning the scene to "normal"	Make assumptions that the employee will be "OK" based on their past coping
Put the employees previous sickness / performance issues behind them – anyone can develop PTSD	Make judgements about the employees "right" to be traumatised. Different experiences at work and outside can contribute to a trauma response.
Allow the person to ventilate their feelings / fears without interrupting too much	Stop the person from talking about their anxieties. Do avoid offering advice about how to overcome their psychological difficulties – they will have their own coping style.
Demonstrate active listening (nods, uttering aha, eye contact, reflecting back, etc)	Rushing conversations
Seek advice / help off others if at all worried (PTH, HR, GP, etc.)	Taking it all on yourself – you may be able to do this a few times, but you risk your own health if you keep taking on all the responsibility without help. Be aware – the trauma experience may cause you some distressing memories. If having problems – seek help immediately.

Do's	Avoid
Allow the person as much as possible the option of determining your management of them in the next 4 weeks. Some may prefer lots of contact thereafter, some may prefer very little.	Decide and then act on the belief that you know what is best for the person.
Try and remove as much of their other stressors, as much as possible (as they relate to work)	Ignore the person's worries
Keep a brief record of discussions, agreements and plans.	Keeping no records

Remember - it is OK to listen to the person talk about the trauma, just avoid giving too much "psychological advice" or attempt "counselling". Be yourself. But, it is OK to discuss other worries / fears (e.g., they may have annual leave / holiday coming up, etc).