Work-related injury, stress, trauma and chronic pain

Australian Federal Police

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Questions

- How many of you are currently operational police practitioners?
- How many of you have ever been operational police practitioners?
- How long ago?
- Vietnam veteran example…

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Motivation to attend this presentation

- Possible economic benefits to your organisation?
- Recognition of the gravity of the human and economic costs to police practitioners and their families and this organisation?
- Frankly, it doesn't really matter because these objectives are ultimately mutually interdependent!
- What is really critical is that we all realise their mutual interdependence. This challenge is not going away, unless we face it squarely

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The parameters of this presentation

- Not a blueprint for change but a beginning in providing context, information, a rationale, a viable process and some sense of the areas that need to change
- A rationale to move beyond fragmented,cosmetic and superficial change!
- A rationale for systematic, structural, organisational and integrated cultural change
- Limited by information and resourcing provided and the time to prepare and to present
- Impossible (today) to adequately contextualise what follows in historical, theoretical, research or clinical terms

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Point to ponder!

- ***"The prevention of crime and the detection and punishment of offenders, the protection of life and property and the preservation of public tranquillity are the direct responsibilities of ordinary citizens. The police are given certain functions to assist the public to do its work but it simply cannot be left to the police"*** **(English Royal Commission on the Police, 1967).**
- **An "over-functioning" policing organisation means the implicit acceptance and accommodation of unrealistic expectations at enormous cost to everyone, including the organisation, police practitioners and their families and policed communities**

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Injury (1)

- Injury, trauma, stress and chronic pain are words that are now commonly used in many contexts but what do they mean?
- Legal definitions try to establish precise and direct links between the presumed causes of these overlapping hurts and health-related, social and vocational outcomes.
- Many organisations in first world countries have procedural guidelines and processes for responding to events that may result in physical and psychological damage to employees

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Injury (2)

- Such protocols and processes often simplify the complex and interactive nature of personal, pre-injury organisational, precipitating event and recovery factors that influence the initial and ongoing emotional and physical health of injured employees and the organisations for which they work.
- The case of “Roger”

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Injury (3)

- The Webster's dictionary (1991) defines injury as, "physical impairment resulting from violence or accident [unjust or offensive treatment, *suffering* from *a sense of injury* // an instance of physical or moral hurt// *(law)* an actionable wrong" (p.498). This definition does not clearly separate the event from the subjective experience of the event and includes both physical and psychological events.
- In legal terms, the notion of workplace injury immediately raises issues of employer liability. Marked distinctions are always made between physical injuries and psychological injuries (Mullany, 2000). These distinctions and the interpretation of their definitions vary considerably within and across legal jurisdictions as do the accompanying physical and psychiatric impairment rating scales.

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Injury (4)

- In finalising his commentary on some history, recommendations for reform and current definitions of workplace injuries, Prof Nicholas Mullany had this to say…
- *" For so long as deeply rooted scepticism and misconceptions concerning mental illness are given voice via the floodgates myth, true equality in legal protection and treatment of physical and psychiatric injury will remain elusive. The commitment to "minimalist intervention" and misplaced homage paid to unsubstantiated concerns of an inundation of unmeritorious actions have combined to generate a regime of reform which falls short of the comprehensive overhaul so desperately required to remedy the appalling state of English psychiatric damage law" (Mullany, 2000. p. 75).*

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Stress (1)

- Many perspectives on police stress are descriptive rather than truly explanatory
- Some assume homogeneity of both appraisal and experience for individual police.
- Police are frequently categorised into simplified typologies, which deny individual complexity and uniqueness.
- Some writers propose prescriptive and linear stage models of policing or suggest static personality traits either at recruitment or in response to policing environments.
- Unjustified stereotyping of police and sweeping generalisations about their behaviour

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Stress (2)

- The **nature** hypotheses- police stress is exclusively associated with the biology, personalities or characters of individual police
- The **nurture** hypotheses- assume police stress is purely environmental-necessarily cumulative and do not explain individual differences such as healthy adaptations to policing environments.
- Even "**interactional**" hypotheses often do not explain the process of relationships between multiple variables and police stress reactions
- Research into police stress is often conceptually confused, unsystematic, and oversimplified. This limits our ability to compare, generalise, and replicate many findings
- Stressors and their consequences have frequently been compartmentalised (eg organisational vs traumatic) as if they occur in isolation from the experiencing police person

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Trauma

- The definition of a traumatic event provided by (DSM-IV) in delineating the diagnostic criteria for PTSD is a useful starting point for defining trauma.
- Simultaneously defines trauma in terms of an external event and a subjective response
- Includes a definition of a traumatic event that must involve experiencing, witnessing or being confronted with actual or threatened death, or serious injury to self or others. In addition, it must include a personal response of intense fear, helplessness or horror.
- Provides us with an explicit focus, comparative options and a boundary in discussing traumatic events. This definition still allows enough conceptual space to explore the complex and multiple personal and systemic processes involved in truly beginning to understand and respond appropriately to occupational traumatisation.

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Trauma (2)

- The DSM-IV criteria for PTSD does create problems in understanding employees where it is not at all occupationally sanctioned to acknowledge feelings of intense fear, helplessness and horror.
- Examples among police, military personnel, nurses, medical practitioners, ambulance drivers, fire fighters and prison officers
- The DSM-IV description of a traumatic stressor may also be inappropriate for all trauma survivors with PTSD. By definition, such traumatised people are emotionally numb and not in touch with their feelings and therefore may have trouble in identifying and expressing feelings of fear, helplessness or horror.

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Post-Traumatic Stress Disorder (PTSD)

- To obtain a diagnosis of PTSD categories of the event and intrusive, avoidance and numbing and heightened arousal symptoms are described.
- Symptoms from these categories must occur in specific combinations and numbers, last for at least a month, and significantly disrupt psychosocial or occupational functioning following exposure to such a traumatic event. A diagnosis of Acute PTSD is given up until three months after the traumatising event and Chronic PTSD after these three months have elapsed.
- A diagnosis of delayed onset of PTSD may also be given if the person only meets diagnostic criteria after at least six months have passed since the traumatising event (American Psychiatric Association, 1994).

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Chronic Pain (1)

- Chronic pain as distinct from acute pain generally lasts longer than a few (about three) months.
- Chronic pain is either always or very frequently present and it is associated with a myriad of contributing factors and consequences and it is usually only minimally responsive to drug treatments.
- The experience and understanding of chronic pain incorporates biological, cultural, emotional, behavioural, relational, cognitive and spiritual meanings
- Chronic pain is invisible and so it is reported or inferred, rather than directly observed. It must be determined to be directly associated with a work-related injury or medical condition to be compensable and to have the costs of treatments met by the relevant insurer.

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Chronic Pain (2)

- Pain Disorder is inferred from clinical presentation, severity and interference in vocational and social and other important areas of functioning.
- Psychological factors may be determined to play a significant role in the onset, severity and maintenance of the disorder and the pain must not be fabricated or better accounted for another disorder.
- It is acceptable for the person to have another concurrent diagnosable psychological disorder.
- Pain Disorders are coded according to the presumed and relative degree of involvement of psychological factors and a general medical condition in the onset, severity and maintenance of the pain (American Psychiatric Association, 1994, p.p. 458-462).

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PTSD and Chronic Pain Disorder

- Clearly, PTSD and Chronic Pain Disorder are medical diagnoses and the use of these terms has significant legal and compensation implications. The use of a diagnosis places hurtful events and their consequences within a scientific classificatory model. Accordingly, you essentially either have PTSD and /or Chronic Pain Disorder or you do not!
- Classification systems inspired by the medical model are static rather than dynamic.

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Longitudinal Course of PTSD

- Most studies investigating occupational trauma have focussed on PTSD. There have not been many longitudinal studies of PTSD in this area.
- PTSD might remit or persist as a chronic form or it might fluctuate in intensity, resolve or even recur
- Some people exposed to multiple events that would clearly met DSM-IV criteria for traumatic stressor events do not apparently develop symptoms or manifest explicit or documented distress.
- We do not know whether such individuals are simply acting out their difficulties in other areas of their life that may ultimately translate in to workplace difficulties (disguised or otherwise) or whether they are somehow resilient to even repeated and severe exposure to traumatic events. Very little work has been done in this area

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Co-morbidity

- Many trauma survivors who are diagnosed with PTSD appear to concurrently meet the criterion for other conditions
- These co-morbid conditions do not occur in all studies but the most common include substance abuse, depression, various diagnoses associated with social adjustment, other anxiety disorders, phobias and obsessive compulsive disorder.
- People with PTSD have also been found to commit suicide eight times more frequently than those without PTSD even after the influence of depression is statistically controlled.
- People diagnosed with PTSD also appear to have more difficulties in their sexual functioning and more physical problems.

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Complex trauma reactions

- There is often a lack of multiple and reliable measures used over time prior to traumatisation. So-called predictor personality traits may be blurred with the complex characterological changes commonly associated with repeated and prolonged trauma exposure either within organisations, prior to employment or both
- Not well researched in occupational groups where repeated and severe exposure is the norm rather than the exception
- These more complex reactions can include changes in physiology, neurobiology, identity, thinking, emotions, relationships and behaviour that are far more pervasive, insidious and more devastating than PTSD.

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Why Change?

- Economic Costs
- Human costs

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Costs

- the proportion of compensation claims which are stress-related is rising in Australia, Britain, and the USA
- stress-related compensation claims represent a significant and disproportionate cost to organisations
- in addition to treatment costs, there are the costs of replacing or retraining staff
- not aware of any studies into the organisational cost-effectiveness of losing trained and experienced police personnel
- even when police do not lodge compensation claims there are economic, personal and organisational costs associated with unrecognised, minimised and/or untreated disorders

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Some direct economic Costs to the AFP/ ACT Policing (1)

- Cost of training police cadets $100,000 to $130,000 approximately
- Costs for current open stress claims,
  - Highest cost claim $137,036
  - Lowest Cost claim $12,655
  - Average costs for claim $46,824
- Future likely costs for an ongoing claim for PTSD could be up to $300,000
- ACT policing- 58 open claims as at October 2002, (last 4 years or premium years)
- Only 1 has not returned to any work in AFP
- ACT policing has ten open claims relating to Stress (all PTSD).
- **10 x a potential $300,000 is 3 million dollars!**

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Some direct economic costs to the AFP/ACT Policing (2)

- All have regular “treatment” (?)
- Time lost 2 weeks to 3 months (?)
- Recently 3 sworn members have received an invalidity pension due to stress–related conditions –injury occurred outside premium years.
- 15 open claims related to outside the premium years- psychological support required for all-formal counselling received by at least 7 in the past
- ACT has 12 open claims related to physical injuries with secondary conditions requiring psychological intervention and treatment e. g pain management, grief, loss (loss of function and career path) - claims fluctuate and may be re-opened
- Hidden economic costs in lost productivity, absenteeism, turnover and workplace corruption and conflict

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Human costs (1)

- Two competing themes evident in the literature on traumatic stress reactions in police.
  - flat denial or minimisation of the possible negative consequences of traumatisation in police, or
  - almost uncritical and unconditional acceptance that traumatic life events necessarily have devastating effects on police.
- anecdotal descriptions and uncontrolled studies with small samples have dominated
- There is a disproportionate discussion of post-shooting trauma often to the exclusion of other potentially traumatising events in policing

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Human costs (2)

- Weight of evidence clearly indicates that most police are frequently exposed to potentially traumatising events, many are significantly distressed and disrupted by these experiences, and a significant minority develop diagnosable PTSD.
  - Intergenerational
  - Intimate Relationships
  - Physical
  - Cognitive
  - Emotional
  - Behavioural
  - Vocational
  - Social
  - Recreational
  - Sense of self, hope, power, worth and future

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Current System

- Is often adversarial
- There are real problems in defining the core issues, the client group and the responsibilities between the various players who become involved in workplace injury, chronic pain and trauma. Unfortunately, misunderstandings, lack of knowledge, difficulties in communication and overt and covert obstruction of recovery and rehabilitation by key stakeholders are very common behaviours (Kenny 1998 a; 1998 b).
- The case of Harry & Fred

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What informs health and vocational outcomes? Personal factors

- pre-existing family of origin dysfunction
- personal or family history of psychological distress
- history of childhood abuse or prior history of other trauma exposure
- neuroticism (?)
- locus of control
- lower resiliency
- less hardiness
- younger age

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What informs health and vocational outcomes? Incident-related

- magnitude and severity of trauma exposure
- multiple versus single exposure
- perception of life threat or of serious injury
- identification with the victim or the situation
- the psychological proximity of the event
- the receipt of intentional injury or harm
- exposure to grotesque sights
- the violent or sudden death of a loved one
- learning of exposure to a noxious agent
- causing death or severe harm to another
- bereavement and loss
- the non-accidental death of children
- perceived lack control and ability to predict outcome

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What informs health and vocational outcomes? Recovery environment

- Traumatisation shatters or badly shakes fundamental meaning structures
- Recovery environment must be conducive to the formation of new meaning structures that accommodate the reality of the traumatic event(s) and consequences
- Ongoing exposure to traumatic stressors
- Perceived lack of consistent and quality social support, Practical Assistance, Information, Emotional Support
- Limited range of safe and effective strategies to deal with overwhelming feelings and heightened physiological arousal
- The experience of personally significant concurrent life stressors
- Inability to make realistic sense out of the traumatic event and of personal reactions

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Societal context of attempts to change (1)

- Circumscribed political terms and managerial contracts
- Police expected to manage profound societal inequalities and deficits and then blamed when the 'symptoms' of these realities continue to manifest as crime (violence), substance abuse, child abuse
- Conflicting agendas i.e. obtaining appropriate levels of initial and ongoing compensation and treatment (injured person) VS financial considerations in denying, minimising or maximising liability
- The invisibility of PTSD, other stress disorders and chronic pain and the societal tendency to distance from pain & suffering and to devise simple understandings and interventions
- Gender and power issues
- Living in a throw away society with very narrow and limited definitions of success

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Societal context of attempts to change (2)

- Ethics, pecuniary interests and true accountability of mental health, rehabilitation and other health professionals insurance organisations, medico-legal consultants,legal advocates
- Ignorance about the role of psychological factors in terms of cause, effect and moderation of health and vocational outcomes
- The inability of non-suffering people to truly "know" the reality of living with these injuries and pain

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Policing Context

- Confusion and conflict over peace - keeping and law-enforcement roles and implications for human resource selection, training and management practices. Being used as the coercive arms of governments
- Perception of “bunker mentality” of senior executive by operational police practitioners and history of “I have a dream management”
- Multiple stressors: eg trauma exposure, managerial knowledge and styles, shortage of experienced staff, work overload, poor operational policing fit for administrative, workstation and IT systems, limited sensitivity to the needs of policing spouses and children, very limited understanding and repertoire of contextualised skills to anticipate and respond to potentially traumatising stressors, limited operational career paths, nature of shift work, criminal justice issues, gender, police-community relationships.

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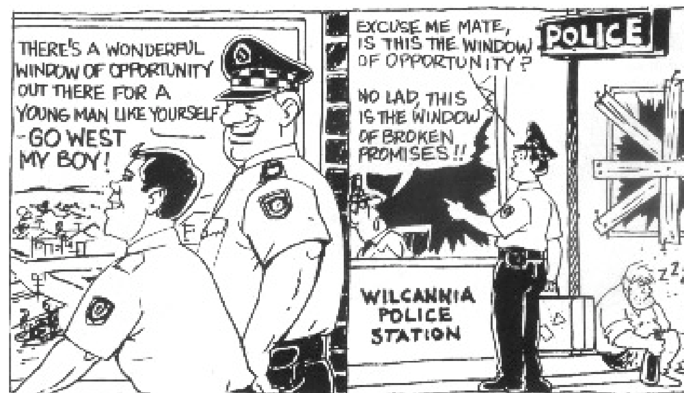
Presumption of unchangeable macho-police culture



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Facts of change

- Must walk, not just talk
- 75% of organisational change programmes fail
- There are negative and positive moderators of change

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Moderators of organisational change

Negative Factors
- Competing resources
- Functional boundaries
- Change skills
- Middle management
- Long IT lead times
- Communication
- Employee opposition
- HR (people/training) issues
- Initiative fatigue
- Unrealistic timetables

From Dunphy and Kirk 2002

Positive Factors
- Ensuring top sponsorship
- Treating people fairly
- Involving employees
- Giving quality comm's
- Providing sufficient training
- Using clear performance measures
- Building teams after change
- Focusing on culture/skill changes
- Rewarding success
- Using internal champions

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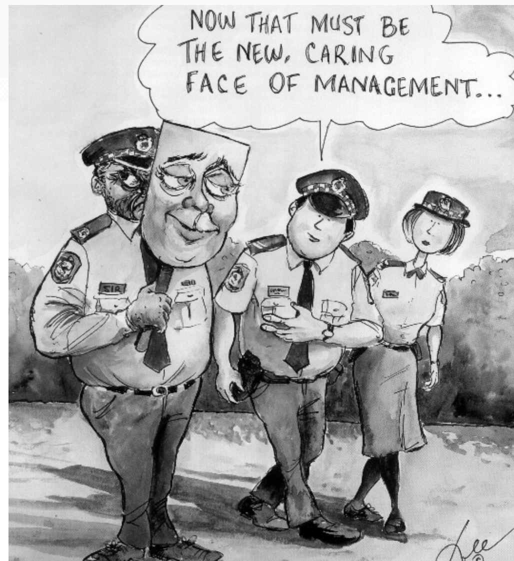

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Areas for Change - Primary (1)

- Active and vital education programme across all levels of the organisation and community
- Integration of all positive moderators of successful organisational change
- Recognition of strengths and courage and resources of injured workers not just problems and deficits
- Staffing levels, support and resources for initial and primary change agents
- Selection
- Rotation for trauma exposure

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Areas for Change - Primary (2)

- Managerial selection, knowledge, styles, performance appraisal and accountability
- Number of experienced staff and capacity for effective buddy systems
- Workload
- Operational policing and ergonomic fit for administrative, workstation and IT systems
- Policing spouses and children
- Broad repertoire of contextualised skills to understand, anticipate and respond to potentially traumatising stressors for all levels within the organisation e.g. verbal judo, tactical disengagement, situational awareness, laying down of survival neural pathways

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Areas for Change - Primary (3)

- Shooting incident protocols
- Operational career paths,
- Nature of shift work
- Criminal justice issues
- Gender issues,
- Police-community relationships
- Incentives for healthy behaviours
- Disentanglement of clinical and personnel functions
- Pay scales and criteria for promotion
- Consultation with operational police
- Initial and ongoing assessment for physical and psychological well-being
- Early safe case identification and responsiveness
- Processes of police accountability

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Areas for Change - Secondary

- Relationships and processes with insurer
- Credibility, authenticity, skill level and resourcing of the people intervening
- Importance of therapeutic relationship issues in predicting outcomes
- Canvassing safe, independent perceptions of EAP and other health and rehabilitation professionals
- Managing vicarious traumatisation of helpers
- Best practice clinical assessment and treatment
- Management of high-risk work environments and employees
- Involvement of policing families and children

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Areas for Change - Tertiary

- Medico-legal processes
- Type and nature of intervention
- Responsibilities of the injured worker
- Non-operational RTW options
- The process of case review and consultation
- Identification and responsiveness to organisational and managerial obstacles to rehabilitation
- Accountability and evaluation processes

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