Author's response to reviews

Title: Development of mental health first aid guidelines for panic attacks: a Delphi study

Authors:

   Claire M Kelly (ckel@unimelb.edu.au)
   Anthony F Jorm (ajorm@unimelb.edu.au)
   Betty A Kitchener (bettyk@unimelb.edu.au)

Version: 3 Date: 11 June 2009

Author's response to reviews: see over
R2: Background and method are far too long, can be much shorter
Previous papers in this series have included shorter introduction and methods sections and we have been asked to expand upon them. With no guidance from the reviewer on what should be removed, I am reluctant to action this suggestion.

R2 [The discussion and conclusion are] too long.
Again, with no guidance from the reviewer on what should be removed, I am reluctant to action this suggestion.

R2 Not enough review of the panic literature, statements are too general.
R2 Probably the literature review is too limited.
R2 [The word] guidelines [in the title and abstract] suggest more than what we get.
I am unsure as to whether this reviewer is referring to the literature search – where we collected statements from – or a review within the paper. This paper was never intended to contain a substantive review. Many excellent review papers have been published in the area of panic, and I have included references to two particularly good recent ones.
If this reviewer is referring to the literature search to find statements to rate, this was not a literature review – it was a search to locate statements which could be seen as first aid items. Clinical advice and promotion and prevention suggestions were not included. This was a very specific type of search, not an exhaustive review. I have refined some of the language and hope this has made it more clear. (page X, para X):

R2 The statements evaluated by the panel are too general, not very specific, and the result is that what you get is common sense.
The audience for these guidelines is not clinical experts or mental health professionals of any sort. It is too easy to describe them as common sense – but for the intended (lay) audience, it is not necessarily obvious. In the same way that first aid for severe bleeding would be obvious to a health professional, but needs to be taught to lay first aiders, the response to a panic attack cannot be assumed to be obvious.

R2 [Limitations of the work are clearly stated,] but what is left out is that the results are not very interesting and how this is possible.
We are sorry to hear that this reviewer does not find the results interesting. Our hope is that the advice contained in the guidelines will be of use to lay people, not clinical or research experts.

R1 Some of the key questions that came to mind are: who are these guidelines directed towards: carers, strangers, or dedicated first aid "helpers". It would be good if the authors clarified this issue. (major compulsory)
Thank you. I have included a brief explanation about this (page X, para X). Just as in regular (physical) first aid, anyone may be the provider; however, first aid is more likely to be provided by a family member or friend, simply because they are the ones most likely to be there at the time first aid is needed. However, many workplaces and organizations have designated first aid officers, our hope is that in the future, there will be designated mental health first aid officers in such organizations.

R1 I would be more confident that someone trained in first-aid with an appropriate basis of knowledge in mental health could tell the difference between a panic attack
and some other acute condition. It is clear that this question was debated amongst the Delphi Groups - what if the first aider is wrong in the "diagnosis" and the person is having some other health-related problem which could be serious if not attended to. Certainly. This is why we caution against the diagnosis and recommend seeking emergency assistance if the person doesn’t know what’s happening to them. Mental health first aid cannot teach people to diagnose a cardiac episode or other medical emergency,

R1 It appears that the authors dealt with this by insisting that the person having the panic attack has had one before and knows what it is. (major compulsory)

This is what was decided on by the panels, not by the authors.

R1 But this still begs the question: what does a first aider do if they come across someone having an episode for the first time. Some further clarification of this would be useful. (major compulsory)

Because a first aider cannot diagnose a panic attack, if the person experiencing the panic attack is unsure, the first aider needs to seek emergency assistance as outlined in the guidelines.

R1 The greatest need would be for those who are having a panic attack while alone in a public place. It is hard to see how practical these first aid guidelines would be in that setting unless, fortuitously, a passer-by has recently been exposed to the source of this information. (Such encounters would be rare for any one “first aider” making it doubtful that their "expertise" would be maintained unless, again fortuitously, they had read the guidelines recently or repeatedly. (major compulsory)

This is a criticism that could be made of mainstream (physical) first aid, too, and unfortunately it is a significant issue. First aid certificates need to be renewed on a regular basis. As a non-accredited training program, Mental Health First Aid cannot make such a requirement of its participants. I have included a brief discussion of this in the limitations (page X, para X).

R1 In the end, is this not a problem that is most effectively dealt with within a self-help and carer framework in relation to those in whom panic attacks occur repeatedly. (major compulsory)

I can’t comment on this – these are not guidelines for ongoing management. Our recommendation, as determined by the panel, is that if the person is having ongoing attacks and is distressed by them that they seek the assistance of a suitable health professional. Ongoing self-help and carer involvement are not within the scope of the current study.

R1 The section on risk factors to panic and agoraphobia could be improved - as it stands, it is a bit confusing. Rather than presenting one sentence for the findings of each study, present some summary statements only. (minor compulsory)

Because the studies report differently on the rates and onset, this is difficult to do without being misleading! I have added a brief explanation (page X, para X):

R1 Paragraph 2 on page 4 could do with greater qualification. As yet, we have no data to show that intervention by a member of the public, a friend, etc, makes any difference. It is reasonable to speculate tentatively that it may! (minor compulsory)

Thank you. Edited to read (page X, para X):

R1 It would be very helpful to the reader to know why carers would not participate since it is not intuitively evident. (…) I do think the authors need to acknowledge that the absence of input from that group has to make the present study at best, very preliminary and that a follow-up study in which carers are included would be vital.
Thank you. I have discussed some of the reasons this may have occurred (page X, para X):
Of course, it is speculation. It is not possible to be sure of why this problem occurred.
I have added a note of caution and suggestion for follow-up research (page X, para X):

R1 I find the dissonance between professionals and consumers about breathing control techniques fascinating and baffling! In particular, it is surprising indeed that the professionals did not shift ground in spite of the views of those who experienced the problem! What does this mean in relation to professionals listening to those who actually suffer?

In the Delphi process, panel members have an opportunity to change their answers to be more in line with other panel members if they do not feel strongly either way, or if they were swayed by alternate opinions. This means that in the case of breathing techniques, either the panel members felt that either breathing management was not important enough to be included in the guidelines, or that there may be problems associated with using these techniques in the long term. As mentioned in the paper (paragraph 2 of the discussion) some panel members raised concern that a reliance on breathing management may inhibit the therapeutic process later on. Alternatively, it may be that the panel members didn’t mind the idea of breathing management but didn’t feel they were important enough to be included in the guidelines. I have added a small amount of additional text to this effect (page X, para X):

R1 I also wondered about the disproportionate representation of academics overall (as a member of this group, I feel able to raise this matter as a potential concern!). Academics notoriously work in highly specialized settings, sometimes rather distant from the context in which front-line first aid would be most offered.

R2 The panel members are not very well and rationally chosen, why the professors and researchers, why not more clinicians? There is not control for real clinical experience by the panel members.

In the Delphi process the aim is to recruit experience- and information-rich individuals, as we were able to do. The aim is not to recruit a representative sample. More academics responded to the recruitment emails. In some ways, the argument could be made that academics are more abreast of the research and have a broader view than a more clinician-heavy panel. Both arguments have merit.