
Guidelines

psychosocial support
for uniformed workers
*Extensive summary and
recommendations*

impact



Trimbos
instituut

Participating organisations



Dutch Police (Politie Nederland)

National Police Services Agency
(Korps Landelijke Politie-diensten – KLDP)

Dutch Police Academy (Politieacademie)

Psychotrauma Diagnose Centre (PDC) Police unit

Fire Department (Nederlandse Vereniging voor
Brandweezorg en Rampenbestrijding – NVBR)

Ambulance Care Netherlands
(Ambulancezorg Nederland – AZN)

National Ambulance Dispatch Center
(Landelijke Meldkamer Ambulance Zorg – LMAZ)

Ministry of Defence

Royal Netherlands Marechaussee (Koninklijke Marechaussee)

Royal Dutch Water Life Saving Association
(Reddingsbrigade Nederland – KNBRD)

Royal Netherlands Sea Rescue Institution
(Koninklijke Nederlandse Reddingsmaatschappij – KNRM).

Dutch College of General Practitioners
(Nederlands Huisartsen Genootschap – NHG)

Netherlands Society of Occupational Medicine (Nederlandse
Vereniging voor Arbeids- en Bedrijfsgeneeskunde – NVAB)

Dutch Association of Psychologists
(Nederlands Instituut van Psychologen – NIP)

Dutch Society for Psychiatry
(Nederlandse Vereniging voor Psychiatrie – NVvP)

Safety region Rotterdam-Rijnmond
(Veiligheidsregio Rotterdam-Rijnmond)

Preamble

psychosocial support
for uniformed workers
European guidelines



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Introduction

A number of professions run a heightened risk of coming into contact with potentially traumatic events.¹ Military personnel is often mentioned in this respect, but for example policemen and fire fighters are also at risk of coming into contact with events of a sudden, unexpected and violent nature. To improve psychosocial support to uniformed workers, a set of guidelines has been developed in the Netherlands (see attached document). The purpose of the preamble you have before you is to add European value to these Guidelines for Psychosocial Support for Uniformed Workers (hereafter: the guidelines).

Why European guidelines?

The Dutch government, uniformed service organisations² (USOs) and mental health care professionals all feel the need for clear standards regarding psychosocial support following traumatic incidents. Therefore, these evidence-based, multi-disciplinary guidelines for psychosocial support for uniformed workers have been developed³. These guidelines describe the way in which uniformed service organisations can offer optimal psychosocial support to their employees, focusing on peer support.

“Why European guidelines?” one might ask. First and foremost, there are few existing guidelines for psychosocial care for uniformed workers⁴. Moreover, up until now there was no systematic evidence-based overview of recommendations for effective use of peer support. At the same time, there is an international desire for more (evidence based) applicable knowledge.

Purpose and structure of the preamble

The guidelines developed in the Netherlands are partly interwoven with the Dutch context. This preamble outlines the international consensus and discussions about guidelines for psychosocial support for uniformed workers. Particular attention is given to peer support following shortly after a potentially traumatic incident. We hope the guidelines will serve as a unifying blueprint for countries that themselves want to develop (additional) guidelines which fit their specific national context. Also, the preamble is the start of the broader development towards a generally recognised European Guideline.

¹ Impact/Trimbos, 2007; Impact, 2008

² In particular the Dutch police, fire department, ambulance service, military and rescue workers.

³ Impact, 2010

⁴ Two (somewhat) comparable guidelines were developed. One by the Australian Centre for Posttraumatic Mental Health (by using Delphi methodology, they developed guidelines for several issues concerning peer support) and a second one in the United Kingdom (the NICE guidelines (NICE stands for National Institute for Health and Clinical Excellence)).

After having explained how the synthesis came to be, we present the core themes about which there is consensus, but also around which the discussion is concentrated. Finally, a number of general conclusions are put forward. We would like to explicitly state that, to best understand the preamble, it should be read together with the summary of the guidelines.

European perspective on the guidelines

Method

Foundations of the guidelines: evidence, experience and consensus

The Dutch guidelines are founded in:

- 1 evidence: scientific (literature) research
- 2 experience: experience-based knowledge derived from focus group discussions, together with the practice based knowledge of the 33 members of the expert boards
- 3 consensus: by bringing together all the stakeholders in different expert boards, consensus was created on key themes

For a more elaborate discussion of the methodology, please see the extensive summary.

What additional research was done for the preamble?

To understand the relevance of and support for the guidelines within a European context, three methods were used: an international conference, a questionnaire distributed amongst experts and a literature review. First, the Amsterdam Conference, held in September 2010 was attended by twenty five experts from ten different countries. Together they commented on the guidelines and discussed how it could apply to their respective national circumstances. Second, the experts who could not attend the conference gave their feedback was by means of a questionnaire.⁵ Also, both the experts who could and could not attend the conference had the opportunity to give feedback on the draft preamble.⁶ Third, an extensive literature review was carried out to assess the evidence base of the guidelines. Three databases⁷ were searched, resulting in over 3,600 publications in which the search terms appeared in the title or abstract.⁸ Two independent reviewers read the abstracts and determined the relevance of the publications for the development of the guidelines.⁹ In case the reviewers disagreed on the relevance, a third reviewer was called in. Based on this method, 199 publications were selected. These 199 publications were then categorised based on the theme(s) they focused on.¹⁰

⁵ Eighteen experts were consulted (all the experts who could not be present and a few participants of the conference). Seventeen experts gave their input by answering multiple choice questions and motivating their answers through written comments.

⁶ The people mentioned below took part in the conference and/or answered the questionnaire. In December 2011 the experts were asked to give feedback on the preamble. All the experts that gave feedback, believe the preamble is a solid outline the international consensus and discussions about guidelines for psychosocial support for uniformed workers.

⁷ PubMed, PsycINFO and Embase.

⁸ Using search terms dealing with uniformed service workers, exposure to potentially shocking events, interventions and actions, outcome measures related to functioning and disability, and a combination of these. The search focused on publications between Jan-1995 and May-2010.

⁹ Inclusion criteria were: 1) system/process: at least one activity dealing with prevention, detection (exposure, prevalence and symptoms), mitigation, or amelioration; 2) outcomes: at least on health condition related effect of (potential) exposure; 3) (proper) study of effectiveness; 4) context: uniformed service workers

¹⁰ Please not that a publication can have more than one topic. On average 1.2 topics were ascribed to an publication.

The majority of these publications deals with causes of psychotrauma (29%), symptoms of psychotrauma (20%) and the prevalence of psychotrauma (20%). Less than half of the articles look at what kind of action can be taken to prevent or cure symptoms of psychotrauma. Prevention, treatment methods (for example Eye Movement Desensitisation and Reprocessing) and the role of debriefing are by far the most studied. Only five publications specifically deal with the use of peer support, making this a particularly understudied field of inquiry. Moreover, it is worth mentioning that the literature predominantly focuses on military personnel (53%). After military personnel, the police is most studied (13%) followed by rescue workers in general¹¹ (11%), emergency medical workers/ambulance personnel (10%) and fire fighters (6%).

Core themes

Based on the literature review, conference and questionnaire, this section highlights the consensus and discussion relating to the application of the Dutch guidelines in an international context. The three phases Mrazek & Haggerty¹² distinguish in psychosocial support after shocking events (preparation, peer support and monitoring, and referral to professional care) served as an ordering principle for the core themes.

Preparation: selection and responsibilities of the employer

Selection of employees as a way of preventing psychosocial trauma

Taking preparation as our starting point, the conference, literature review and board of experts have helped to highlight issues that are particularly interesting in an international context. One of these issues is the selection of employees. Experts believe that it is to some extent possible to reduce psychosocial risk from potentially shocking events by employing uniformed workers with a relatively high degree of resilience and who are not easily stressed.¹³ Also, regular mention is made of people entering a profession with an accumulation of potentially shocking events that make them more susceptible to traumatisation.¹⁴ Unfortunately there are no sufficiently accurate instruments to recommend screening for 'psychological vulnerability'.¹⁵ More in general, the literature shows us that it is very hard to accurately predict who will develop psychosocial trauma after a potentially shocking event and those who will not. That being said, some possibilities may lie in prevention of psychosocial trauma through training/education and pre-deployment stress briefings.¹⁶

Preparation and responsibilities of the employer

Another issue is the responsibility of the employer, both when preparing uniformed workers for potentially traumatic events and when supporting uniformed workers once such an event has taken place. There is general agreement that, as the guidelines suggest, employers have

¹¹ Emergency medical workers, fire fighters and police

¹² Mrazek & Haggerty, 1994

¹³ Note that only 12,5% of the board of experts believed it was possible to reduce the psychosocial risk after experiencing shocking events solely by selection.

¹⁴ Paton, 2005

¹⁵ Rona et al., 2006; Jones et al., 2003; Wessely, 2005; Heslegrave and Colvin 1998.

¹⁶ Sharpley et al., 2008; Deahl et al., 2000.

a responsibility in preparing employees for potentially shocking events. For example by providing psycho-information¹⁷, by adopting watchful waiting (which reactions are normal, when are they cause for concern?) and by promoting adequate help-seeking behaviour.

Consensus also exists about the statement that employers have a general responsibility in the psychosocial care for their employees¹⁸. In several countries the responsibility of the organisation is to some extent formalised in law. Psychosocial care also receives attention in the European Labour Laws. However, the legal basis varies widely and generally does not seem to be sufficient to guarantee adequate psychosocial care. Furthermore, several experts emphasise that psychosocial care is also a moral responsibility of organisations. All in all, the vast majority of the respondents to the questionnaire – 88.2% – (completely) agrees with the statement that formalised peer support should be embedded within the uniformed services and that it is the responsibility of the employer to do so.¹⁹

The third argument, besides the legal and moral considerations, is that an employer can be more cost effective if attention is given to prevention and psychosocial support. Research into the costs of employees who can no longer work due to having experienced traumatic events, is very limited.²⁰ Based on what research findings there are and on the expectations of the experts, the costs can be very significant indeed, ranging from medical expenses to lessened productivity, and to the additional time managers have to invest in dealing with all sorts of issues when the employees performance drops, not to mention the cost (financial, but also in terms of quality of life) to the individuals who experience traumatic events and to society. Many experts believe the financial risk of psycho trauma is not sufficiently acknowledged by employers, let alone that there are enough effective initiatives taken.²¹

So far, the combined legal and moral responsibility, and economic arguments are not enough to protect employees. The guidelines, we hope, will work as an extra stimulus due to their empirical foundations and practical applicability.

Organised peer support

Peer support in relation to other forms of support and organisational instruments

Having a supportive context is crucial to enhancing the resilience of uniformed workers.²² The guidelines focus on how this context can be provided by uniformed workers themselves. In which case the task of 'organised peer support' is to support colleagues who have experienced a shocking event.

In accordance with existing research and the guidelines, the experts at the Amsterdam Conference, agree that peer support is a very important way of signaling psychosocial problems and possibly promoting resilience. In terms of empirical foundations, little research has been

¹⁷ Psycho-information is geared towards increasing the practical self-reliance of uniformed workers by acknowledgment and recognition of the experience

¹⁸ The board of experts was unanimous in that everybody believes that the employer is, to some extent, responsible for psychosocial care.

¹⁹ None of the respondents disagrees with this statement.

²⁰ One notable exception is Haagsma et al., 2011.

²¹ EUTOPA-IP Amsterdam Conference, 2010.

²² CREST, 2003; Impact/Trimbos, 2007; Forbes et al., 2007.

done into the importance and effect of peer support. The systematic literature review highlights this point vividly: five articles (out of 3.600) explicitly deal with peer support, and none of these articles are based on controlled trials.

One of the ways in which the existing literature does prove valuable, is that it highlights a few interesting advantages/strengths peer support has (in comparison to professional care). Uniformed workers tend to be a closed in-group in which seeking professional psychological help can imply weakness, cowardice or an inability to perform the job effectively. Conversely, mental health professionals are seen as out-group who do not understand the culture in USOs.²³ In this complicated setting, peer support in USOs offers easily accessible support without which some uniformed workers would only come forward with their symptoms once they have become too severe. What is more, peer support may have a preventive effect on the development traumatic symptoms.²⁴ Like Levenson and Dwyer state "peer support during a crisis facilitates the process of psychological closure and mourning and enables emergency services workers to cope more effectively with tragedy so they can continue to perform their jobs efficiently and with satisfaction".²⁵

Alongside peer support, there are also other social bonds that play a role in the support process. Several studies looked at who are the most important people surrounding somebody who just experienced a shocking event. De Soir²⁶ found that right after an incident it is a colleague, then family and then the boss that is seen as important.²⁷ After a number of weeks, the most important person became the boss, then the family and as third the colleague. Another example is research conducted with troops going on a mission. Findings show that military personnel with a private environment that is relatively stable, are less vulnerable to psycho trauma.

One issue this highlights, is that peers are important to uniformed workers who just experienced a potentially traumatic event, but that others are important as well. The experts consulted through the questionnaire and Amsterdam Conference could not agree more: almost all experts believes that, next to colleagues, also supervisors, family and social workers are important.

A particularly interesting category in this respect is religion. Unanimously the experts believe religion plays a role in psychosocial support.²⁸ Germany is perhaps the clearest example where this is implemented accordingly: German psychosocial support is given by emergency priests. Also on missions abroad, an emergency priest accompanies the group of uniformed workers. Peer support as described in the guidelines has only recently been initiated.

When broadening our perspective even wider and looking at more than direct interpersonal support, the literature suggests there are other variables that can influence the psychosocial wellbeing of uniformed workers who just experienced a potentially traumatic incident. A few

²³ Dowling et al., 2005; Levenson and Dwyer, 2003.

²⁴ Ryan and MacLochlainn, 1995; Dowling et al., 2005; Levenson and Dwyer, 2003.

²⁵ Levenson and Dwyer, 2003.

²⁶ De Soir, 1997.

²⁷ People who had recently (within a week) experienced a potentially traumatic incident were asked (through a questionnaire) who was most important in providing support. The same question was asked three months later.

²⁸ 100% of the respondents answered they believe religion is an actor in the provision of psychosocial support.

of these variables are:

- Organisational culture / belief structures of groups of employees: experts and the literature report great differences in the acceptance of peer support by uniformed workers and the acceptance that incidence can have traumatic effects.²⁹ Differences between organisations, for example between fire fighters and the military, are reported, and variations between countries.
- Group cohesion and trust amongst colleagues:³⁰ this theme deals with such questions as: Do you feel safe, both physically and psychologically, amongst your direct colleagues? Can you fall back on and receive support from direct colleagues?
- Leadership and the role of manager: the literature pays attention to forms of leadership/ management in general (for example hierarchical leadership versus empowering/coaching leadership) and what leaders do in case of potentially shocking events in particular.³¹

These variables can be seen as taking a step back from the concrete potentially traumatic incident, and looking at what organisational variables – often described in terms of occupational stressors – influence the development of psychosocial trauma.

Again, little research has been done in this field. Thus there is not yet much solid evidence on the extent to which these variables/instruments are effective in helping to reduce trauma related stress symptoms, the impact of group cohesion perhaps being the most studied so far. In the future, it is worth further investigating these instruments/variables. For example the degree of effect they have and in what form they can best be implemented.

The scope of peer support

The peer support tasks as identified in the guidelines are important tasks that should be performed by peer supporters in each country, so the participating experts believe. These tasks that should be performed are:

- 1 the provision of practical assistance;
- 2 the stimulation of a healthy recovery process;
- 3 early identification of possible (psychosocial) problems and timely referral to professional help;
- 4 monitoring of the healing process;
- 5 activation of the social network;
- 6 attention for (negative) reactions from the environment

First of all, it should be mentioned that the present situation in the different Member States is not or only partially in accordance with these tasks: peer support does not exist in each EU Member State, at least not within all the uniformed services. Secondly, when it comes to defining tasks, the guidelines explicitly do not incorporate therapeutic tasks. Therapy, so the guidelines argue, is something that should only be provided by professional therapists. Letting uniformed workers perform (even a light form of) therapy on their colleagues can worsen the trauma, because the uniformed workers are not sufficiently trained and experienced to perform therapy.

²⁹ Dowling et al., 2005; Levenson and Dwyer, 2003.

³⁰ Svensson & Fridlund, 2008; Brailey, 2007.

³¹ Castro, 2009

The practice in several countries is that there is a therapeutic component to peer support. For example in Denmark, but also in Canada. The Canadian Operational Stress Injury Social Support (OSISS) Program provides confidential peer support and social support to veterans, and their families, affected by an operational stress injury resulting from military service. Also, there is a large minority of experts that believe this therapeutic component is desirable.³² This is not to say that experts believe that peer support is a form of mental healthcare: most respondents to the questionnaire (completely) agree with the statement that, for fear of over medicalisation, peer support should not be presented as a form of mental health care. Moreover, 81% of respondents do not believe that peer supporters should be able to execute tasks of mental health professionals.

Looking at the literature, a similar, be it implicit, discussion exists about the medicalisation of peer support. On the one hand, there are authors who describe the tasks of peer support much along the same lines as the guidelines.³³ Dowling et al. for example researched the tasks of peer supporters in the New York Police Department and state: "their [peer supporters'] role is to screen, support and act as a bridge towards professional assistance".³⁴ On the other hand, there are researchers who see peer support as part of or a light form of professional mental health care.³⁵ For example, Linton describes "using a team composed of both mental health professionals and peer support personnel" when employing the technique of critical incident stress management (CISM).³⁶

The effects of different forms of peer support, have not yet been researched sufficiently to unambiguously say if therapy provided by peer supporters has negative or positive effects.³⁷ However, there is consensus – in research findings and between experts – that all the peer support tasks mentioned in the guidelines are indeed important. Because of its limited scope, one could say it is a "dummy proof" form of peer support, on which, some experts would suggest, a therapeutic component can be added.

Required knowledge and experience for peer support

Who should be a peer supporter? The answers to this question vary considerably between countries. Again, the guidelines prove to be a common ground, upon which competencies/requirements are added in a number of countries. In the literature³⁸ and amongst the experts at the Amsterdam Conference, the following selection criteria for people who want to become peer supporters have centre stage:

- acceptance, respect and trust amongst peers
- a robust, energetic personality
- able to listen, have empathy and strong interpersonal skills in general

³² 40% of the respondents in the digital board believes that peer supporters should do more than detection, alerting, advice for referral and long-term monitoring.

³³ Hattingh, 2002; Dowling et al., 2005;

³⁴ Dowling et al., 2005: 870.

³⁵ Linton, 1995; Ryan K, MacLochlainn, 1995.

³⁶ Linton, 1995.

³⁷ The existing literature does often not explicitly distinguish between therapeutic and the non-therapeutic use of peer support.

³⁸ Hattingh, 2002.

³⁸ Castro, 2009

That being said, there are some differences between countries. An important one is the selection of peer supporters who themselves had trauma symptoms (the use of the method of the “wounded healer”). In Canada peer supporters must have had an illness related to their deployment such as depression, addiction or an anxiety disorder. They should be well into their healing, but not symptom free. Having had an illness themselves is expected to help peer supporters better understand their colleagues and thereby better help them. In other countries, like Germany and Denmark this approach is not used. One reason being that complications arose because peer supporters were dealing with their own trauma, which was further triggered by their conversations as peer supporters. A second reason for not using the method of the wounded healer may be that the peer supporters are not expected to get too personally involved (in the therapeutic treatment process).

In accordance with the guidelines, some form of training is always provided to peer supporters. However, the amount of training is quite different. In Belgium and France, peer supporters in fire fighting have eight days of training plus four residential periods of three days³⁹. By contrast, in the Netherlands, two days of training are commonplace in the police force, with one yearly follow-up training day. Another example is Nordrhein-Westfalen, where professionals fire fighters have two days of basic training, followed by eight and a half days of psychosocial support training.

Overall, 75.1% of respondents (completely) agree with the selection, training, education and the role of the organisation as described in the guidelines.⁴⁰ They feel these are well researched recommendations. Suggestions are made with respect to screening for previous trauma and adequately training individuals for what they can expect in ‘the field.’

Use of professional care

Referral to professional care

Peer supporters, together with management, direct colleagues and family/friends, have an import role in the timely recognition and referral of employees who show clear signs of a disrupted recovery. The experts and literature review fully support the guidelines in this respect. At the same time, the issue of referral touches on the scope of peer support. The guidelines propose a strict separation between support (provided, amongst others, by colleagues through peer support) and treatment (provided by professional healthcare). This separation is commonplace in the Netherlands, but not always in other countries. For example in Belgium and France, after potentially traumatic events, the involved policemen are invited by a psychologist for counseling. So professional care is provided immediately after an incident, alongside peer support.

³⁹ A somewhat similar duration of training can be seen in Canada (two weeks), Denmark (two weeks) and Luxemburg (five weekends).

⁴⁰ 18.8% of the respondents (totally) disagrees. Unfortunately, no motivations are provided.

This variation between countries is reflected in the answers given in the questionnaire. A majority of respondents – 68.8% – (completely) agree that initial support should consist of peer support. At the same time, a number of experts comment that there is also a need for direct involvement by mental health care professionals, depending on the kind of event, resources available and whether or not individuals want to make use of peer support. Also, some experts suggest that a less strict distinction is necessary between peer support and mental health care. For instance, in many cases debriefing is done by peer support under the supervision of mental health care professionals.

Conclusions

Consensus: resilience, organisational responsibility, and basic tasks peer support

The starting point of the guidelines is the capacity of an individual uniformed worker to promote his/her own recovery. Focusing on people's own resilience is the first point of consensus. When confronted with shocking events, it is by no means certain somebody will become traumatised. People have a "natural" resilience that, together with the help of their social environment, enables them to cope. The majority of people are able to cope with shocking events without the need of professional help. What is more, it has been researched that stigmatising people as being ill, can prevent the recovery process. The stigmatisation can enforce people's sense of being a victim, leading to passive behaviour.

Taking the resilience of an individual uniformed worker as the basis for developing the guidelines, does not mean the employer has no responsibilities. As we mentioned, there are legal, financial and some would say moral reasons for an employer to make sure uniformed workers receive psychosocial care. The vast majority of the consulted experts agree that psychosocial care is, to some extent, a responsibility of the organisation. However, so far, the (financial) risk and responsibilities of psycho trauma are not sufficiently acknowledged by employers.

Thirdly, consensus exists about the tasks ascribed to peer support in the guidelines. Peer support should always be directed toward (practical) assistance, stimulating healthy recovery and if necessary referral to professional care. The experts agree that these non-medical tasks of peer support are for the basis for any task definition.

Discussion: scope of peer support, other organisational interventions, and timing of professional care

There is expert consensus about the question whether peer support is a valuable instrument in the prevention of psychosocial trauma (the existing literature also places much value on peer support, but controlled trials have not yet been carried out). Alongside peer support, however, there are also other instruments that may prevent psychosocial trauma. Influencing belief structures/culture in organisations, the degree of trust amongst direct colleagues, and altering tasks or deployment of employees are a few examples of what an organisation can do when trying to influence the development of psychosocial trauma.

Even though there is consensus about the tasks ascribed to peer support in the guidelines, there is discussion about the adding of a therapeutic component to peer support. In several countries, it is practice that peer supporters have a supportive role in therapy. Whether or not this is more effective than peer support with no therapeutic component cannot definitively be answered based on existing research. This may very well be one of the issues that depend on the national context and that should be taken into account when implementing the guidelines.

Finally, there is discussion about when the professional care providers should get involved. Only once they have been alerted by peer supporters, the employees themselves or their superiors? Or should they automatically be alerted in the case of particularly grave events and/or employees that are already experiencing symptoms of psychosocial trauma?

Implementation

All in all, the available literature and consulted experts believe that the guidelines form a solid foundation for psychosocial support for uniformed workers. When implementing the guidelines, two things are particularly important. First of all, as the discussion points out, there are differences between countries and these differences have to be taken into account when implementing guidelines. This means that additions to the guidelines might be necessary to accommodate the national context. Second, effective implementation is by no means only dependent on the quality of the guidelines. It is very important to put in place a process that creates attention and backing for the guidelines amongst key stakeholders.

Project partners and participating experts

Project Partners

- City of Cologne, Germany (beneficiary)
- Centre of Psychotraumatology, Alexianer Krefeld GmbH, Germany
- Impact - Dutch knowledge & advice centre for post-disaster psychosocial care, The Netherlands
- Charles University in Prague, Faculty of Philosophy, Czech Republic
- Sociedad Española de Psicotraumatología y Estrés Traumático (SEPET), Madrid, Spain
- Public Health Department, Düsseldorf, Germany

Participating experts Amsterdam Conference⁴¹

Participants at the Amsterdam Conference

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Bruno Brito	Portugal
Michel Dückers	The Netherlands
Ira Helsloot	The Netherlands (only September 16)
Henriette Hoogendorp	The Netherlands
Leonie Hoijsink	The Netherlands
Eric Geerligs	The Netherlands (discussion leader)
Michaela Krtsickova	Czech Republic
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Jonathan Bisson	Wales (United Kingdom)
Chris Brewin	United Kingdom
Mark Creamer	Australia
Neil Greenberg	United Kingdom
Mark Walsh	United Kingdom

⁴¹ The Amsterdam Conference took place on the 16th and 17th of September 2010.

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⁴² This literature was used in the preamble. Part of this literature, particularly the five publications dealing directly with peer support, is an addition to the Guidelines for Psychosocial Support for Uniformed Workers (2010).

Preamble

psychosocial support
for uniformed workers
European guidelines

Guidelines

psychosocial support
for uniformed workers
*Extensive summary and
recommendations*



Colofon

This summary was commissioned by the Dutch ministry of Security and Justice

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Introduction

Uniformed emergency service providers – hereafter called ‘uniformed workers’ – run a heightened risk of coming into contact with events of a sudden, unexpected and violent nature (Impact/Trimbos, 2007; Impact, 2008). In the Netherlands, the uniformed service organisations (USOs) have provisions for the psychosocial support of the service’s own staff, usually in the form of peer support.

Psychosocial care for uniformed workers must be offered in accordance with the most recent, demonstrably effective and usable practices. The realisation, implementation and monitoring of psychosocial interventions are, however, in fact often dependent on the insights of USOs, individual service providers and sometimes of commercial companies. This means that interventions are offered in different ways, and that uniformed workers do not always receive optimal care. Sometimes interventions are implemented which have never been scientifically researched, or, worse, which research shows are not effective or efficient.

A need was felt for a clear standard by the Dutch government, the USOs in question and the mental health care professionals involved. Therefore, in collaboration with the police, fire department, ambulance service, Ministry of Defence and rescue workers, the evidence-based multi-disciplinary guidelines for Psychosocial Support for Uniformed Workers were developed (Impact, 2010). These guidelines describe the way in which USOs provide optimal psychosocial support for their employees. They contain recommendations for the employees themselves, for peer support, for supervisors and for management.

The above mentioned organisations accept the guidelines as the standard for psychosocial support of uniformed workers after shocking events. However, this does not mean the work is done. Steps must now be taken to implement the recommendations within each USO. The guidelines will be used in the (further) development of procedures and protocols for psychosocial support. It is important to monitor this process of implementation into practice, so that input is obtained for the intended review of the guidelines in 2016. Adjusting guidelines such as these to progressive insights is a way of closing the gap between theory (what *should* be done) and practice (what is *actually* being done).

About this summary

This is an English summary of the Dutch multi-disciplinary guidelines for Psychosocial Support for Uniformed Workers (Impact, 2010). To our knowledge, to date no systematic evidence-based guidelines for optimal psychosocial support within USOs exist, although a related initiative was taken by the Australian Centre for Posttraumatic Mental Health, who developed guidelines on a range of issues concerning peer support using the Delphi methodology.¹

The guidelines described in this summary were developed within the Dutch context, but the basic principles and recommendations are relevant in a broader international context. In addition, the guidelines are based upon international scientific literature. By making the Dutch guidelines available for an international public, an incentive is given to further the development of (research on) psychosocial support within USOs, and perhaps even to develop internationally accepted guidelines.

This summary is comprised of two parts:

- Part A describes the background and methodological development of the guidelines.
- Part B summarises the guidelines. A full overview of all (55) recommendations in the guidelines is set out in Appendix 3.

A complete list of references is also included. This base of literature was used in the development of the guidelines. Not all references are referred to in this summary. Specific considerations referring to the Dutch context and particular regions within the Netherlands have been omitted in this summary, as well as practical examples.

¹ Australian Centre for Posttraumatic Mental Health, January 2011. *Development of guidelines on peer support using the Delphi methodology.*

A Guidelines *background*

The guidelines for Psychosocial Support for Uniformed Workers (hereafter referred to as 'the guidelines') were prepared at the request of the Dutch Ministry of Security and Justice (the former Ministry of Internal Affairs and Kingdom Relations, Safety Directorate-General). They were developed by Impact, the Dutch knowledge and advice centre for post-disaster psychosocial care. The quality control bureau of the Netherlands Society of Occupational Medicine, and the Trimbos Institute provided methodological support during the development.

A multi-disciplinary project group and steering group was formed. The members of these groups represented the relevant USOs and the four trade associations of professionals in psychosocial care (an overview of all USOs involved can be found in Appendix 1). The task of the steering group was to monitor the progress and to consent on the quality of the end result.² The project group provided input on the development of the guidelines and the formulation of its recommendations.³ During the procedure of formulating the guidelines, there was continual contact and consultation between the project group and the steering group. In addition, when needed, smaller subgroups were formed to discuss specific matters in further detail.

The development of the guidelines took place in accordance with the method of Evidence-based Guideline Development (EBRO). Vantage point are a number of 'starting questions' based on a first list of issues or problems experienced when providing care to uniformed workers after disasters and shocking events. These starting questions covered a range of aspects, including the nature and goals of the guidelines (definition of target group, delineation of the incidences the guidelines are meant for), the actual support given (in prevention, acute care, and aftercare), and monitoring. In total 34 starting questions were formulated.

An initial literature search was carried out on the basis of the starting questions. At a later stage, a more 'generic' search was also carried out following additional questions from the project and steering group. Specifics of the literature search conducted are included in Appendix 2. The quality of the articles used was evaluated using checklists of the EBRO platform (Manual for Workgroup Members CBO 2005), followed by an assessment for methodological quality.

The project group found that the available and consulted scientific literature focuses primarily on posttraumatic stress disorder (PTSD). The project group would like to emphasise that although PTSD can occur after disasters, terrorism and other shocking events, there are various other psychological consequences which are receiving less attention in the literature. These

² The multi-disciplinary steering group was chaired by professor Niek Klazinga, Senior Lecturer Social Medicine at the Academic Medical Centre in Amsterdam (AMC). Vice-chairman was professor Jan Swinkels, psychiatrist affiliated with the AMC and senior lecturer in guideline development in the health care sector.

³ The multi-disciplinary project group was chaired by Menno van Duin, PhD, lecturer in Crisis Management at the Netherlands Institute for Safety (NIFV).

include depressive disorders, anxiety disorders, medically unexplained physical symptoms (MUPS) and substance abuse.

In formulating specific recommendations, other aspects are often relevant in addition to scientific proof, for example: current practice, costs, cultural preferences, availability of resources and organisational aspects. These other considerations were systematically charted within the project group. In addition, six focus group meetings were organised at various levels within the organisation (management, operational chiefs, peer support, uniformed workers) to better and more directly chart existing practices. Focus groups were particularly useful for determining the (often implicit) reasoning behind the opinions and input of participants.

On the basis of the results of scientific research in combination with other considerations of the project group members, evidence-based conclusions were drawn and recommendations were formulated. Regarding starting questions that could not be addressed due to lack of clear evidence or conflicting opinions within the project group, recommendations for further research were made. A complete overview of all recommendations is set out in Appendix 3 of this summary.

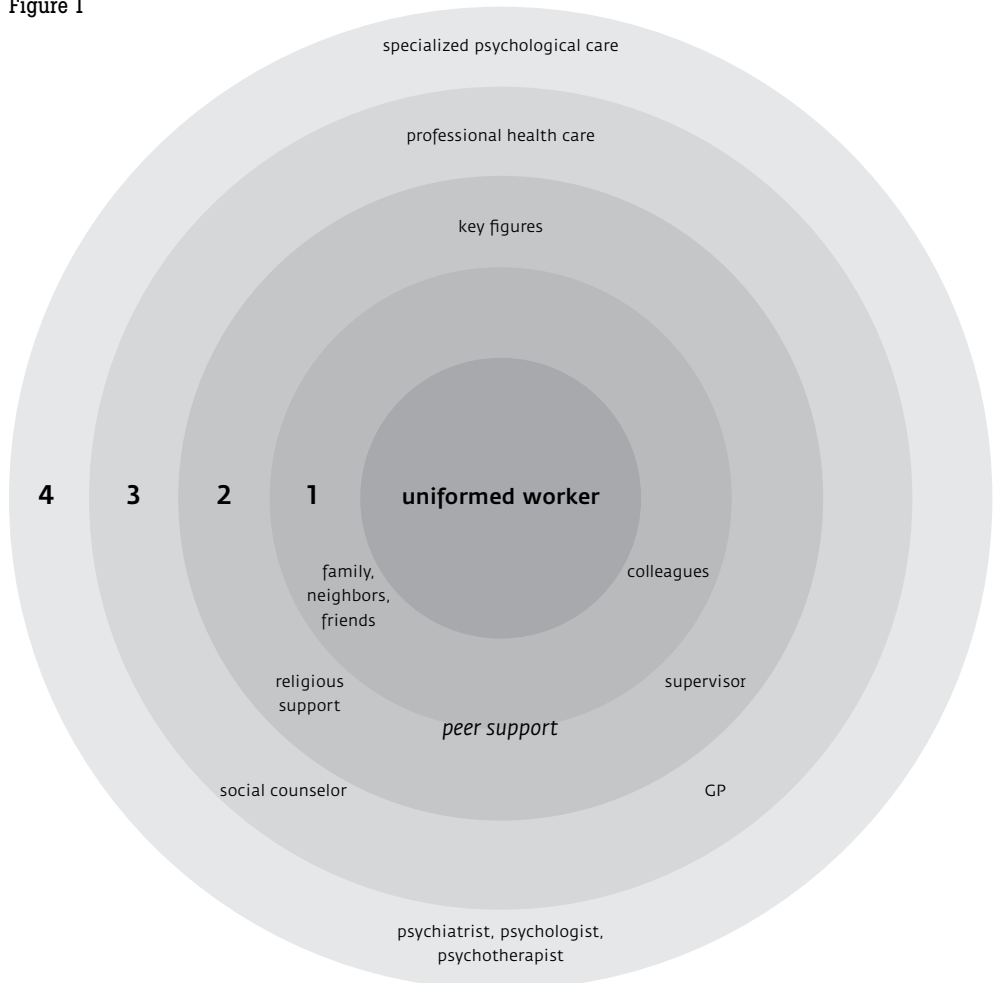
Research shows that during the development of guidelines, little attention is given to planned and structured implementation (Fleuren et al., 2009). During the development of the guidelines presented here, attention was given to implementation from an early stage. A "usability test" took place, in which the key recommendations of the draft guidelines were tested for applicability in practice. During this test, uniformed workers received information on the key recommendations and a checklist of indicators. The applicability of these indicators in connection with a *real life* case were then discussed.

The draft guidelines were presented for comments and approval to the rank and file of the project group members. In addition, at this stage a number of additional organisations were consulted to comment on the draft guidelines (see Appendix 1). After processing all comments and the results of the usability test, the definite guidelines were established and, ultimately, they were authorised by the relevant organisations.

B Guidelines *summary*

The gist of the guidelines' approach to psychosocial support for uniformed workers is shown in Figure 1. This approach is based on a process model for psychosocial support used by the Dutch civil mental health care service, and is also employed within the Dutch armed forces. An important basic principle of this model is the ability of people to promote their own recovery, and the phased use of professional assistance to support that recovery.

Figure 1



The model assumes that care for uniformed workers starts with the uniformed worker him- or herself. At the centre of the model, the uniformed worker bears responsibility for his/her own health. When necessary, support can be found in the surrounding circles. Moving to the outer circles, increasingly more professional assistance becomes available. The first circle is comprised of family, friends and colleagues. The second circle consists of support that is not counted as part of professional mental health care but is comprised of supervisors or organised peer support. The third circle corresponds with 'first-line health care': general practitioners and social workers can offer solutions and treatments in this circle. When there are severe psychiatric or psychosocial problems one should receive professional (trauma-related) mental help in the fourth circle (Gersons, 2005).

The realm of influence for the USO primarily lies in the innermost circles (0, 1 and 2). Psychosocial support should take place within these inner circles, thereby promoting the individual's self-efficacy (Impact/Trimbos, 2007). Three phases can be distinguished in psychosocial support after shocking events, which can be reconciled with the above-described circle model (Mrazek & Haggerty, 1994).

- 1 *Preparation: selection, information and training (prevention) (circles 0 and 1 of the model)*
This phase is concerned with interventions/actions preceding exposure to shocking events, including the selection and training of uniformed workers, and providing them with information. The role of the USO is also dealt with in this phase.
- 2 *Peer support and monitoring (circles 1 and 2 of the model)*
This phase relates to the first support after a shocking event. The activities of organised peer support (such as in-company peer support teams) and the role of supervisors also belong to this phase.
- 3 *Referral to professional care (circles 2, 3 and 4 of the model)*
This phase is about the care provision by professional (mental) health care providers, when necessary.

In the following, each of these phases is described in more detail.

Preparation: selection, information and the role of the organisation

Psychosocial support for uniformed workers starts with good employment practices. This entails that within the USO attention is given to factors that promote psychological resilience, such as the provision of a motivating mission statement, opportunities for career development, social support, feedback and evaluation via teamwork and inspiring leadership. In addition, there should be attention for the reduction of risk factors, such as an excessive workload, emotionally demanding work and procedural and relational injustice within the USO (Dowden and Tellier, 2004; Netherlands Center for Occupational Diseases (NCvB), 1999; The Social and Economic Council of the Netherlands (SER), 2009; Walburg, 2008).

There is a broad range of possible consequences of shocking events (Impact/Trimbos, 2007), that can last for years after an incident (Benedek et al., 2007; Forbes et al., 2007; Morren et al., 2007; Witteveen et al., 2007; Bills et al., 2008). Possible psychosocial consequences of shocking events for uniformed workers are: dysfunctional behaviour, anxiety complaints, increased absenteeism, increased substance abuse, problems in private lives, emotional withdrawal, acute stress syndrome, PTSD, depressive disorder, sleep disorder, work conflicts and occupational disability. Unfortunately, there are no sufficiently accurate instruments to recommend screening for 'psychological vulnerability' (Heslegrave and Colvin 1998; Jones et al., 2003; Wesseley, 2005; Rona et al., 2006). Research into stress management training for uniformed workers points out that such training programs do not have a significant effect on the development of disorders after exposure to shocking events (Deahl et al., 2000; Cigrang et al., 2003; Williams et al., 2004; Williams et al., 2007).

Factors which play a role in the development of psychosocial problems are, inter alia, the degree of exposure to potentially shocking events, work satisfaction and engagement, work-specific problems (lack of safety, role uncertainty), physical injury, and (societal) acknowledgement or criticism of the action. With regard to the latter, the media also play an important role. The uniformed worker needs to be prepared for (negative) external reactions as well as the possibility of follow-up investigations (Koren et al., 2006; Richter et al., 2006; Forbes et al., 2007; MacGregor et al., 2009). This also applies in connection to dealing with aggression. In the Netherlands, aggression of bystanders towards uniformed workers seems to be increasing and is currently receiving a lot of attention in the media. The USOs have reacted to this trend by including this theme in their training. A literature study of Richter et al.(2006) indicates that training in how to deal with aggression within the mental health and disability care, improves knowledge of dealing with violence and increases the confidence in one's own ability in this area. An additional effect of the USO offering aggression training courses is that it sends out the signal that the uniformed workers' security is taken seriously.

Informing uniformed workers on how to deal with shocking events can be done by providing psycho-information. Psycho-information is focused at increasing the practical self-efficacy of uniformed workers. Important in this respect is the acknowledgment and recognition of the (shocking) experience. Psycho-information also emphasises the importance of aspects like *watchful waiting* (which reactions are normal, when are they a cause for concern?) and the promotion of adequate help-seeking behaviour. This form of information should not only be provided directly following an incident, but should be brought to the employee's attention at an earlier stage (e.g. during training).

Organised peer support and monitoring

There is broad consensus on the usefulness of providing a supportive context to prevent the occurrence of psychosocial problems (CREST, 2003; Impact/Trimbos, 2007; Forbes et al., 2007). Within a USO this context can be offered by uniformed workers themselves. Such 'organised peer support' can help to mobilise the social network, it contributes to an open work culture, it simplifies finding professional assistance and it has a signalling and referral function if professional help is necessary. Organised peer support also applies to most, if not all USOs, and aligns with current practice (Broersen and Bos, 2002).

The task of organised peer support is to support colleagues who have experienced a shocking event. In executing this task, attention must be given to the following:

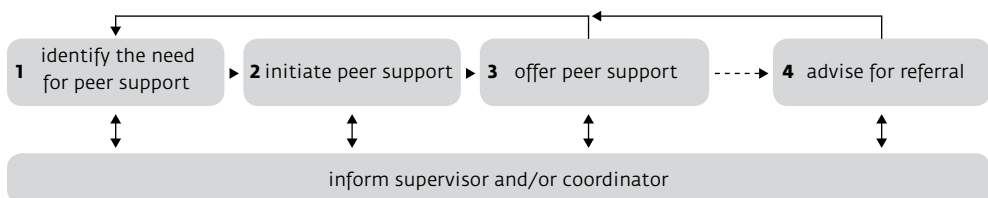
- 1 the provision of practical assistance;
- 2 the stimulation of a healthy recovery process;
- 3 early identification of possible (psychosocial) problems and timely referral to professional help;
- 4 monitoring of the recovery process;
- 5 activation of the social network;
- 6 (negative) reactions from the environment.

In the execution of organised peer support, four steps can be distinguished:

- 1 identification of the need for the use of peer support (i.e. establishing that there was exposure to a shocking event);
- 2 calling in peer support/appointing a peer supporter;
- 3 supporting a colleague in accordance with the above-mentioned aspects;
- 4 if necessary, advising the uniformed worker to contact professional help.

These steps are shown in Figure 2. By providing repeated support and keeping an eye on the uniformed worker's wellbeing, structured monitoring is achieved. In addition, it is important that the supervisor is informed that the affected uniformed worker gets peer support, for the supervisor is responsible for personnel care (it should be emphasised that no information is shared about the contents of the interviews with peer support members).

Figure 2



supervisor is responsible for personnel care (it should be emphasized that no information is shared about the contents of the interviews with peer support members).

There is variation between (*and within*) USOs in the criteria used to identify the need to deploy peer support. Nevertheless, based on an inventory of the different criteria used, a generic set of common 'deployment criteria' was determined. This consists of:

- serious injury or threat (especially when children are involved);
- involvement of family or colleagues of the uniformed worker;
- sense of helplessness on the part of the uniformed worker;
- the uniformed worker him-/herself indicating a need for support;
- violence used against the uniformed worker.

USOs are advised to use this basic set of criteria, and if needed to complement it with additional, specific deployment criteria.

The detection (by colleagues, peer supporters or the supervisor) of psychosocial problems can also take place during an operational debriefing. An operational debriefing is defined as a *post-event discussion with an operational character where determining the facts is the main objective; the emphasis is not laid upon the emotional experience as other interventions are considered to be more appropriate for tackling this*. An operational debriefing is important for eliminating factual questions ('completing of the puzzle') and to avoid the repeating of mistakes in the future.

It is important for the uniformed worker to have the opportunity to tell his or her own story, within which emotions can have a place. It is not advised, however, to 'actively' ask questions about feelings and emotions shortly after an incident. This relates to discussions about the practice of 'psychological debriefing', which is defined as *Any single session psychological intervention that involves some reworking, reliving, or recollection of the trauma and subsequent emotional reactions* (Rose et al., 2002). Research has shown that such interventions are not effective; there are even indications that they worsen the psychosocial consequences (Rose et al., 2002; Sijbrandij et al., 2006; Morren et al., 2007; Roberts et al., 2009). Although these conclusions are based on research among the general population, there is no evidence that the early care provided should be different for the various USOs (Peñaalba et al., 2008; Jones et al., 2003; Greenberg et al., 2008). The techniques involved in a psychological debriefing are therefore not advised.

The actual deployment of organised peer support is comprised of a first interview, followed by further follow-up interviews if these are found to be necessary. The timing of the first interview with a peer supporter is relevant. If this is too soon after the incident, it can be harmful for the natural recovery process (in line with the previous comment on psychological debriefing). It is also important that the uniformed worker is not 'kept' too long within the peer support system – if more professional (mental) help is needed, the individual should receive such help as soon as possible. It is therefore recommended to carry out a maximum of three interviews; if problems persist, the uniformed worker must be advised to seek contact with professional

assistance. The interviews with peer support can roughly be held in the following interval: a first interview a few days after the incident, a second (if needed) after four to six weeks and a third (if needed) after three months. Although all of the above is essential in organising peer support systems within USOs, it should not detract from the key point that there must be a working culture in which talking about one's emotions is accepted, and that there is room (at any time) to tell one's story.

Competencies that are important for members of organised peer support and which should be addressed in selection and training, are:

- communication skills;
- the ability to listen;
- empathy;
- a robust, energetic personality;
- independence;
- reliability/ confidentiality.

Monitoring uniformed workers who have been exposed to a shocking event is important for detecting psychosocial problems on time. Although short screening questionnaires have been used for this purpose (NICE, 2005; Forbes et al., 2007), it is not recommended to use clinically validated screening lists during the actual interviews by peer support – the use thereof must be left to professional (mental health) care providers. However, the topics raised in screening lists can serve as a starting point, or guidance, during the interviews by peer support.

Supervisors have a task in signalling problems in uniformed workers and must therefore have a certain knowledge and skill level (Forbes et al., 2007; Fuoppala et al., 2008). This knowledge should encompass at least the following aspects:

- knowledge of the effects of experiencing a traumatic event on people and their social context;
- skills for the early detection of psychosocial problems;
- knowledge of the course of the recovery process;
- knowledge of factors influencing the recovery process;
- knowledge of the possible (temporary) consequences for functioning;
- knowledge of what actions to take in the event of trauma-related absenteeism;
- knowledge of how to offer practical and social support;
- knowledge of the use of and possible need for adjustments in work activities;
- knowledge of the provisions for (professional) care within the USO;
- skills to support the uniformed worker;
- knowledge of the tasks, organisation and working method of the peer support system and how to deploy peer support;
- after determining (serious) psychiatric problems, the ability to motivate the uniformed worker to seek professional care.

Organised peer support merits a distinct position within each USO. The task of coordination – the monitoring and assessment of activities of peer support – is ideally assigned to one person. This prevents the tasks from being carried out in a fragmented way. A “registration system” in which a record is kept for each uniformed worker regarding any incidents they were involved in, can also contribute to better case services. However, careful privacy regulations need to be put in place when using a registration system. The information conveyed during the peer support interview should remain within that context of confidentiality.

Use of professional care

Timely recognition and referral of employees who are absent due to fear and/or depressive disorders leads to reduced complaints and a quicker return to work (Rebergen et al., 2009). The principle of 'psychological triage' is relevant in this respect (Impact/Trimbos, 2007). Psychological triage means that after a shocking event, a distinction should be made between 1) people who are able to recover on their own, 2) people who are *at risk* of developing more severe, chronic complaints and 3) people who show clear signs of a disrupted recovery process and who need direct professional care. For the first and second group, a 'watchful-waiting' policy is advisable during the first four to six weeks. Also, a supportive context is particularly relevant in this phase (NICE, 2005, Impact/Trimbos, 2007). To distinguish between the different groups, the following indications/signals of a disrupted recovery process are relevant:

- having disturbing memories of-, or dreams about the event;
- getting upset by recurrent memories of the event;
- having physical stress reactions;
- avoidance behaviour, absenteeism;
- having sleeping problems;
- increased irritability or having a 'short fuse';
- being overly alert;
- having mood swings;
- having concentration problems;
- increased alcohol or drug use;
- impairment in functioning (at work and at home);
- fear and shame.

If a uniformed worker shows a alarming quantity of the above indications/signals, it is recommended to advise him or her to contact professional care.

Finally, it is recommended to make use of existing guidelines and protocols in the area of support and psychosocial after-care (e.g. as set out in Trimbos/Impact, 2007, NICE, 2005). It is important that an USO has knowledge of the available treatments.

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Appendix 1

Organisations involved with this guideline

The primary target group of these guidelines are Dutch uniformed workers and the organisation in which they work (uniformed service organisations – USOs). Uniformed workers are defined as follows: uniformed workers whose task it is to provide assistance after incidents and disasters from an organised professional context.

The following organisations were actively involved with the development of these guidelines:

- Dutch Police (Politie Nederland)
- National Police Services Agency (Korps Landelijke Politiediensten – KLPD)
- Fire Department (Nederlandse Vereniging voor Brandweezorg en Rampenbestrijding – NVBR)
- Ambulance Care Netherlands (Ambulancezorg Nederland – AZN)
- National Ambulance Dispatch Center (Landelijke Meldkamer Ambulance Zorg – LMAZ)
- Ministry of Defence
- Royal Netherlands Marechaussee (Koninklijke Marechaussee)
- Royal Dutch Water Life Saving Association (Reddingsbrigade Nederland – KNBRD)
- Royal Netherlands Sea Rescue Institution (Koninklijke Nederlandse Reddingsmaatschappij – KNRM)

In addition, the recommendations included in these guidelines are relevant for professional emergency service providers who might be involved in the psychosocial (after-)care of uniformed workers after potentially shocking events. The following organisations were actively involved with the development of these guidelines:

- Dutch College of General Practitioners (Nederlands Huisartsen Genootschap – NHG)
- Netherlands Society of Occupational Medicine (Nederlandse Vereniging voor Arbeids- en Bedrijfsgezondheidskunde – NVAB)
- Dutch Association of Psychologists (Nederlands Instituut van Psychologen – NIP)
- Dutch Society for Psychiatry (Nederlandse Vereniging voor Psychiatrie – NVvP)

In addition to the above/mentioned organisations, the following organisations (among others) contributed to the final editing process of the guidelines:

- Spiritual counselling (both within the ministry of defence and within the Dutch police organisation)
- Netherlands Press Council (Raad voor de Journalistiek – RvJ)
- Netherlands Red Cross (Nederlandse Rode kruis)
- Victim Support, the Netherlands (Slachtofferhulp Nederland)
- Association of Dutch Municipalities (Vereniging van Nederlandse Gemeenten – VNG)

Appendix 2

Description of literature search

A first basic search of the available literature was carried out at the end of 2008. An supplementary literature search was carried out in August 2009, partly on the basis of additional questions formulated by the project group. Both searches are described below.

Results of the basic search

The search for relevant scientific literature as of 1996 was performed in the databases Medline (PubMed), EMBASE and PsycINFO. Initially the focus was on existing guidelines, systematic reviews and randomized controlled trials (RCTs) in the area of psychosocial support and supervision of assistance providers after disasters. Use was made of, inter alia, the search strategy for intervention with work-related problems developed and validated by Cochrane Occupational Health Field.

Sensitive search according to Cochrane Occupational Health Field strategy, search terms: traumatic stress, disaster workers, rescue workers

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(effect*[tw] OR control*[tw] OR evaluation*[tw] OR program*[tw]) AND (work[tw] OR works*[tw] OR work'*[tw] OR worka*[tw] OR worke*[tw] OR workg*[tw] OR worki*[tw] OR workl*[tw] OR workp*[tw] OR occupation*[tw] OR prevention*[tw] OR protect*[tw]) AND ("Stress Disorders, Post-Traumatic"[Mesh] OR "Stress Disorders, Traumatic"[Mesh] OR "Stress Disorders, Traumatic, Acute"[Mesh]) AND disaster workers OR rescue workers
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Identical keywords were used in EMBASE and PsycINFO. This search resulted (particularly by limiting it to emergency service providers) in 98 hits; a further selection took place with Limits. An identical search with 'trauma workers' instead of 'disaster workers' OR 'rescue workers' resulted in 93 hits, some the same as those already found; a further selection took place with Limits. A subsequent search was carried out using search terms such as rescue workers, police officers, fire fighters, ambulance personnel, military, peer support, recuperation and sleep management. Also, a general search strategy described by Haafkens (2006) was employed. Furthermore, the literature used in the NICE guidelines PTSD (2005) was examined. This resulted in a few supplementary articles.

Description of literature selection

The 132 abstracts found in the first search were assessed as to content and quality. Articles were included that described research into the (psychosocial) consequences of disasters for (uniformed) assistance providers or describing the effectiveness of interventions in the area of psychosocial support and supervision within this target group. As a result, a lot of articles were excluded, as they primarily focused on the civilian victims of disasters or on post-traumatic stress disorders in general. Using the snowball method, we went through the bibliographies of the resulting 35 articles and selected a number of additional articles. In total, this procedure led to 44 selected articles, the entire texts of which were examined. Of these 44 articles, most related to the

general consequences of disasters; far fewer articles focussed on what to do after a disaster. In the end, 8 articles were presented to the project group.

Results of the supplementary search

This search further focussed on the consequences of disasters for (uniformed) workers. Systematic reviews and meta-analyses as of 1995 were included, in the languages Dutch, English, French, German and Spanish. This search was carried out in PsycInfo, PubMed and PILOTS (which is a database with trauma-related articles). A sensitive search was chosen to obtain the largest possible yield. When defining the search terms, use was made of the Cochrane Occupational Health Field strategy.

A first, general search was geared to reviews, and used a combination of terms relating to the specific professional groups, trauma and work (stress). In this search, which partly replicated the search conducted in the guidelines early psychosocial interventions after disasters, terrorism and other shocking events (Impact, 2007), 116 articles were found. From this pool, 21 articles were selected concerning work-related aggression, characteristics of employees and increased risk or protection of psychiatric problems.

Uniformed workers

DE "Rescue Workers" or DE "Fire Fighters" or DE "Police Personnel" or (DE "Emergency Services") OR DE "Military Personnel" OR DE "Air Force Personnel" OR DE "Army Personnel" OR DE "Coast Guard Personnel" OR DE "Commissioned Officers" OR DE "Enlisted Military Personnel" OR DE "Marine Personnel" OR DE "Military Medical Personnel" OR DE "Military Psychologists" OR DE "National Guard Personnel" OR DE "Navy Personnel" OR DE "ROTC Students" OR DE "Volunteer Military Personnel" OR TI (red cross OR disaster responders OR disaster work* OR rescue handler* OR trauma work* OR trauma intervent* OR rescue and recovery worker* OR armed forces OR ambulance personnel OR ambulance service worker* OR rescuers OR uniformed health care work* OR emergency personnel OR emergency services personnel OR emergency nurs*) or AB (red cross OR disaster responders OR disaster work* OR rescue handler* OR trauma work* OR trauma intervent* OR rescue and recovery worker* OR armed forces OR ambulance personnel OR ambulance service worker* OR rescuers OR uniformed health care work* OR emergency personnel OR emergency services personnel OR emergency nurs*) or KW (red cross OR disaster responders OR disaster work* OR rescue handler* OR trauma work* OR trauma intervent* OR rescue and recovery worker* OR armed forces OR ambulance personnel OR ambulance service worker* OR rescuers OR uniformed health care work* OR emergency personnel OR emergency services personnel OR emergency nurs*) OR TI (fire service personnel OR accident and emergency work* OR emergency nurs*) or AB (fire service personnel OR accident and emergency work* OR emergency nurs*) or KW (fire service personnel OR accident and emergency work* OR emergency nurs*) OR TI (helping profession* OR mental health professional*) or AB (helping profession* OR mental health professional*) or KW (helping profession* OR mental health professional*) OR DE "Medical Personnel" or DE "Military Medical Personnel" or DE "Nurses" or DE "Health Personnel" or DE "Allied Health Personnel" or DE "Occupational Therapists" or DE "Counselors" or DE "General Practitioners" or DE "Physicians" or DE "Psychologists" OR DE "Clinical Psychologists" OR DE "Counseling Psychologists" OR DE "Educational Psychologists" OR DE "Experimental Psychologists" OR DE "Industrial Psychologists" OR DE "Military Psychologists" OR DE "Social Psychologists" or DE "Psychotherapists" OR DE "Hypnotherapists" OR DE "Psychoanalysts" or DE "Therapists" or DE "Clinicians" or DE "Juries" or DE "Judges" OR DE "Impaired Professionals"

Trauma

KW psychological N2 debriefing or TI psychological N2 debriefing or AB psychological N2 debriefing OR DE Debriefing (Experimental) or DE Debriefing (Psychological) or DE "Emotional Trauma" or DE "Posttraumatic Stress Disorder" or DE "Psychological Stress" or DE "Terrorism" or DE "Distress" or DE "Survivors" or DE "Stress" OR DE "Chronic Stress" OR DE "Environmental Stress" OR DE "Financial Strain" OR DE "Occupational Stress" OR DE "Physiological Stress" OR DE "Psychological Stress" OR DE "Social Stress" OR DE "Stress Reactions" or DE "Acute Stress Disorder" or DE "Disasters" or DE "Natural Disasters" or DE "Violence" OR DE "Family Violence" OR DE "Patient Violence" OR DE "School Violence" OR DE "Violent Crime" or DE "Violent Crime" OR DE "Family Violence" OR DE "Homicide" OR DE "Physical Abuse" OR DE "Political Assassination" OR DE "Rape" OR DE "Terrorism" or DE "Homicide" or DE "Genocide" OR TI critical incidents or AB critical incidents or KW critical incidents

Work-related stress/general work-related problems

DE "Occupational Stress" or DE "Occupational Exposure" or DE "Stress" or DE "Stress Reactions" or DE "Stress Management" or DE "Caregiver Burden" or DE "Impaired Professionals" OR ((TI work OR works* OR work* OR worka* OR worke* OR workg* OR worki* OR workl* OR workp* OR occupation* OR prevention* OR protect*) or AB (work OR works* OR work* OR worka* OR worke* OR workg* OR worki* OR workl* OR workp* OR occupation* OR prevention* OR protect*) AND DE "Posttraumatic Stress Disorder"

An additional search was conducted to answer a number of specific questions, concerning the following subjects:

Effectiveness of training (175 articles)

(skill based intervention* OR social problem solving program* OR social problem solving approach* OR psychological skills intervention* OR psychological skills training) "peer support" DE "Social Support" OR DE "Social Networks" OR DE "Online Social Networks" OR DE "Support Groups" OR DE "Twelve Step Programs" staff education "Prevention" coping behavior or KW coping strategies morbidity "Debriefing (Experimental)" or DE "Debriefing (Psychological)"

Effectiveness of selection methods (54 articles)

(DE "Job Performance" OR DE "Employee Efficiency" OR DE "Employee Productivity") or (DE "Personnel Recruitment") or (DE "Coping Behavior") vulnerability "Susceptibility (Disorders)" or (DE "Prediction") or (DE "Morbidity") "Personnel Selection" OR DE "Job Applicant Interviews" OR DE "Job Applicant Screening" or DE "Selection Tests" OR DE "Psychological Screening Inventory" or DE "Military Recruitment" (helping profession* OR mental health professional*) or AB (helping profession* OR mental health professional*) or KW (helping profession* OR mental health professional*)(fire service personnel OR accident and emergency work* OR emergency nurs*)

Association between physical injuries and psychiatric consequences (223 articles)

(physical trauma* OR physical damag*) or AB (physical trauma* OR physical damag*) or KW (physical trauma* OR physical damag*) (DE "Wounds" or DE "Injuries" or DE "Burns" or DE "Electrical Injuries" or DE "Head Injuries" or DE "Brain Concussion" or DE "Traumatic Brain Injury")

Role of chronic (work related) stress and frequently occurring incidents (151 articles)

(secondary trauma) or (empathic strain) or (compassion fatigue)) or TI=((vicarious traumatization) or (vicarious trauma) or (secondary victimization))) OR (AB=((secondary trauma) or (empathic strain) or (compassion fatigue)) or AB=((vicarious traumatization) or (vicarious trauma) or (secondary victimization))) OR (DE=("vicarious traumatization" or "trauma contagion")) OR ((TI=((secondary trauma) or (empathic strain) or (compassion fatigue)) or TI=((vicarious traumatization) or (vicarious trauma) or (secondary victimization))) or (AB=((secondary trauma) or (empathic strain) or (compassion fatigue)) or AB=((vicarious traumatization) or (vicarious trauma) or (secondary victimization))) or (DE=("vicarious traumatization" or "trauma contagion")))) and((DE="burnout") or (TI=(chronic stress) or AB=(chronic stress)))) and(rct or random*)

Social attention (200 articles)

(DE "Public Opinion") and (DE "Mass Media" or DE "Communications Media" OR DE "Audiovisual Communications Media" OR DE "Mass Media" OR DE "Telecommunications Media" or DE "News Media" OR DE "Newspapers" or DE "Printed Communications Media" OR DE "Books" OR DE "Magazines" OR DE "Newspapers" or DE "Television" OR DE "Closed Circuit Television" OR DE "Educational Television" OR DE "Television Advertising")"public attention" [ti] OR "public awareness" [ti] "Disaster Medicine"[Mesh]

Effectiveness of debriefing and psychological information (96 articles)

TI (debriefing OR crisis intervention) or AB (debriefing OR crisis intervention) or KW (debriefing OR crisis intervention) psychoeducation[tiab] OR "Patient Education as Topic"[Mesh] OR "psychological skills training*" [tiab] OR motivational interviewing[tiab] OR "patient teaching"[tiab] OR "patient instruction"[tiab] OR "patient information"[tiab] OR "patient knowledge"[tiab] OR (patient[tiab] AND (educational program[tiab] OR educational programing[tiab] OR educational programme[tiab] OR educational programmes[tiab] OR educational programming[tiab] OR educational programs[tiab] OR educational programs/schools[tiab] OR educational intervention[tiab] OR educational interventions[tiab]))

Effectiveness of peer support (97 articles)

(DE "Impaired Professionals" DE "Vicarious Experiences""peer support"[All Fields] OR "Social Support"[Mesh] OR "Self-Help Groups"[Mesh] "colleague support")

Role of supervisors (112 articles)

("leadership" OR "employer" OR "supervisor" OR "manager" AND "job performance")

Effectiveness of stress management, professional (company) health care (167 articles)

(adjustment disorders[MeSH Terms] OR burnout, professional[MeSH Terms] OR work stress[Text Word] OR occupational stress[Text Word] OR job stress[Text Word] OR neurasthenia[MeSH Terms] OR minor depression[Text Word] OR ((mixed[All Fields] AND (anxiety[MeSH Terms] OR anxiety[Text Word])) AND ((depressive disorder[MeSH Terms] OR depression[MeSH Terms]) OR depression[Text Word])) OR emotional disorder[Text Word]) AND ("stressmanagement\ OR timing feedback\ OR "return to work\ OR (occupational AND therap*) OR (occupational AND intervention*) OR " OR "work capacity evaluation\ OR "vocational guidance\ OR absenteeism OR "occupational health services\ OR "occupational health\ OR "sick leave\ OR "sickness absence\ OR occupation* OR job)

Description of literature selection

A total of 1391 articles resulted from these searches. After an assessment on the basis of the titles of these articles, the abstracts of 227 articles were examined. The full texts of 59 articles were then reviewed, of which 15 articles were meta-analyses. Of these 15 articles the bibliographies were reviewed by means of the snowball method and a few additional articles were selected. Of the remaining 65 articles, 7 were presented to the reading groups which were formed from the project group, accompanied by a number of questions relating to the quality and applicability of these articles. For each question, the reading groups assessed which articles were suitable. The scientific conclusions of the articles were then incorporated in the guidelines.

Appendix 3

Complete overview of recommendations

This appendix contains a complete overview of the recommendations formulated in the Guidelines for Psychosocial Support for Uniformed Workers. The recommendations are chronologically represented according to the structure of the guidelines, and cover the following topics:

- Vision and context (recommendations 1 – 12);
- Preparation: selection, information and the role of the organisation (recommendations 13 – 16);
- Organised peer support and monitoring (recommendation 17 – 48); and
- Deployment of professional care (recommendations 49 – 55).

Vision and context

Potentially shocking events: definition and possible consequences

- 1 The project group recommends using the A1 criterion of the PTSS diagnosis according to the DSM-IV to define a potentially shocking event, and to expand this to other possible psychiatric complaints and disorders. The A1 criterion reads: the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
- 2 After potentially shocking events, the following psychiatric and psychosocial consequences should be taken into account: disfunctioning; anxiety complaints; increase in absenteeism; increase in substance abuse; problems in the uniformed worker's private life; insensitivity; emotional withdrawal; acute stress syndrome; posttraumatic stress syndrome; depressive disorder; sleep disorders; conflicts at work; and occupational disability.

Risk-increasing and protective factors

- 3 General risk-increasing and protective factors for the development of PTSS after a shocking event are (within the general population):

pre-trauma factors

- previous traumatisation
- previous psychopathology
- neuroticism

peri-trauma factors

- severity of the trauma

post-trauma factors

- social support
- additional sources of stress

The project group furthermore advises being alert to situations in which uniformed workers do not talk about the trauma they experienced, avoid specific tasks and activities or seek types of distraction which are harmful to the individual or his or her social context (e.g. substance abuse).

- 4** The project group states that psychosocial support of uniformed workers starts with being a good employer. To this end, the USO pays attention to factors which promote mental resilience, like an appealing mission, development possibilities, social support, feedback and valuation via teamwork and inspiring and serving leadership. In addition, there is attention for the reduction of risk factors such as work pressure, emotionally demanding work, and procedural and relational injustice within the organisation.
- 5** In addition to the aforementioned general factors, which also apply to uniformed workers, the project group emphasises the importance of offering social support. With regard to uniformed workers special attention must be paid to:
 - a** acknowledgement;
 - b** the opportunity of 'telling the story';
 - c** after-care and supportive discussions; and
 - d** information on the actions of other parties involved.In addition the uniformed worker must be protected as best as possible – inter alia by means of information and preparation – from possible (negative) reactions from the environment and follow-up investigations, as well as aggression.
- 6** The project group recommends further research into risk-increasing factors and in particular protective factors, because this enables the USO to take measures to prevent later problems in the recovery process.
- 7** The project group recommends taking into account that physical injury during a potentially shocking event can increase the psychosocial impact on uniformed workers.
- 8** Media coverage (in particular negative coverage) deserves attention in the after-care for uniformed workers. The project group recommends that USOs are alert to the effects of media coverage after shocking events in relation to the health of the uniformed workers involved.
- 9** The project group recommends using (already existing) protocols for dealing with aggression, insofar as this applies within the USO.

Responsibility for the psychiatric well-being of uniformed workers

- 10** Although Dutch legislature makes the employer responsible for the psychological well-being of uniformed workers, the most recent legislation does not make any clear statement on the specific realisation thereof. It is therefore recommended that USOs determine and document their responsibilities for the care of their employees.
- 11** The USO has a responsibility for paying continuous attention to the existing risk factors for developing work-related stress disorders following shocking events. For example, this can be done by including psychosocial well-being in an occupational health examination.
- 12** Organisations must create working conditions which reduce negative consequences of shocking events on the psychological health of uniformed workers.

Preparation: selection, information and the role of the organisation

- 13** There is insufficient evidence to recommend screening potential uniformed workers to reduce the incidence of psychological complaints or reduced work performance.
- 14** The project group recommends describing examples of successful after-care and peer support practices and embedding these practices within the various USOs.
- 15** In the framework of being a good employer, the project group emphasises the importance of periodic health examinations, preventive medical examinations and/or employee satisfaction surveys. In addition, an organised incident handling is necessary, within which:
 - 1 good training and professional personnel is provided;
 - 2 the roles and responsibilities of the care providers have been clearly documented;
 - 3 professional assistance is readily available.
- 16** The project group recommends doing more (qualitative) research into the effects of prevention policies on the reduction of complaints among uniformed workers.

Organised peer support and monitoring

Basic principles

Supporting context: what kind of support is effective?

- 17** The project group advises creating a supportive context by means of a 'form of peer support whereby an attempt is made to provide employees exposed to work-related potentially traumatic experiences with support and psychosocial care to prevent reduced deployability'. This peer support aligns with the working method as is currently offered by most USOs in the Netherlands.
- 18** In order to provide optimal psychosocial care within organisations, the project group recommends the deployment of peer support, to be optimally established and supported by the USO using the approach and frameworks outlined in this guideline.

Peer support and related interventions

- 19** The project group recommends using the terms operational debriefing and psycho-information and avoiding the use of the term psychological debriefing.
- 20** The project group recommends freeing up time for operational debriefing (if possible, multi-disciplinary), noting that emotional aspects of the experience should not receive explicit attention in this context.
- 21** Despite insufficient scientific evidence for the effectiveness of providing information, the project group recommends providing uniformed workers with 'psycho-information' to improve mental resilience. Psycho-information should be geared towards increasing the practical self-sufficiency of uniformed workers and their work context, by acknowledging and recognising their experiences, by emphasising the importance of aspects like watchful waiting, by monitoring uniformed workers in their functioning and, if applicable, by promoting adequate help-seeking behaviour. This form of information must not only be provided after an incident, but should be brought under the employee's attention beforehand.

The organisation of peer support

Core of organised peer support

22 The project group recommends using organised peer support. Peer support is recognisable for the uniformed worker and lowers the threshold to actually seek help. From this generic starting point, it is up to each USO to come up with a structure which 'fits' within the own organisation.

23 The project group points out that organised peer support should support colleagues after a shocking event, paying attention to:

- 1 the provision of practical assistance;
- 2 the stimulation of a healthy recovery process;
- 3 early identification of possible (psychosocial) problems and timely referral to professional help;
- 4 the monitoring of the recovery process;
- 5 activation of the social network;
- 6 (negative) reactions from the environment.

Within the USO, these aspects can be supplemented with organisation-specific aspects.

24 The project group recommends multi-disciplinary post-discussion (operational debriefing) for USOs who were jointly involved in a shocking event.

25 The project group recommends the application of four steps within organised peer support:

- 1 establishing exposure to a potentially shocking event;
- 2 initiation of peer support (calling in / appointing peer supporter);
- 3 providing organised peer support for colleague(s) (i.e., the six tasks mentioned in recommendation 23);
- 4 (if necessary:) recommendation for further referral.

The supervisor must be briefed as of the first step and briefing should be continued during the process of organised peer support. The supervisor him- or herself can also initiate organised peer support, e.g. after operational debriefing. The USO determines who implements these steps.

Initiation of organised peer support

26 The project group recommends to use the definition of a potentially shocking event as described in recommendation 1 when considering the initiation of organised peer support.

27 The project group recommends the following general deployment criteria which can be complemented by the USO. The initiation of peer support must be considered with incidents concerning:

- serious injury or threat (particularly when children are involved);
- involvement of family or colleagues;
- feelings of powerlessness on the part of the (uniformed) worker;
- uniformed workers who indicate being in need of support;
- direct violence against the uniformed worker.

28 In principle, organised peer support is only initiated in work-related incidents. Of course, on the basis of being a good employer, also non-work-related incidents can be the subject of peer support.

29 The project group recommends the USO to set up its own basic incident list with specific deployment criteria, in which the above points of attention and considerations are integrated.

- 30** The project group recommends sharing this basic list of incidents among various USOs. This enables alignment and the exchange of experience and considerations.
- 31** The supervisor can initiate organised peer support after an operational debriefing. The project group recommends that a supervisor must be skilled/trained in identifying uniformed workers in need of support.

Offering organised peer support

- 32** The first interview with the organised peer support structure should take place a few days after the actual exposure, i.e. not immediately following the incident. This does not alter the fact that within the organisation there must also be a supporting context within which, if so desired, there is room to air emotions and tell one's story.
- 33** The project group recommends staging the organised peer support as follows:
 - First interview: a few days after the incident.
 - Second interview: after four to six weeks.
 - Third interview: after three months.
- 34** The project group recommends that a maximum of 3 interviews are carried out within organised peer support in accordance with the above-mentioned phasing. After that the uniformed worker must be advised to seek professional help.
- 35** In addition to its supportive function, peer support also has a function in early detection.
- 36** Confidentiality is a key issue during the contacts with members of the organised peer support, but certain conditions apply:
 - 1 confidentiality is no 'privilege', i.e. a peer supporter does not have the right to remain silent in court on the basis of his relationship with the uniformed worker⁴;
 - 2 based on the issues discussed during the contacts, a peer supporter can decide that the uniformed worker must be protected against him-/herself;
 - 3 if the uniformed worker demonstrates offensive, reproachable or criminal actions during the contact, this can lead to a dilemma for the peer supporter.

Prior to the interview with peer support, these conditions must have been made clear to the uniformed worker involved and if necessary the interview can be stopped.
- 37** The contact with organised peer support should get priority over fact finding, unless the investigating body Public Prosecution has substantial reasons for acting otherwise.

Required knowledge and skills for participation in organised peer support

- 38** The project group recommends embedding the training for participation in organised peer support within the organisation. Attention must be paid to discussion skills (individually and within a group context), a basic knowledge of psychological trauma, shocking events and the potential results thereof, and being able to recognise problems in recovering after the incident.
- 39** Every employee has a responsibility to maintain his/her own employability, not only by keeping his/her knowledge and professional skills up to date, but also by keeping an eye on his/her health and psychological well-being. The employee must be informed on a regular basis of the possibility to receive (professional) help.

⁴ Based on the legal definition of 'privilege', as set out on the internet site of the case law of the Supreme Court of the Netherlands: <http://www.rechtspraak.nl>, accessed on 24 September 2010.

40 Competencies which are relevant for peer supporters and which should be dealt with in the training:

- communication skills;
- good listening skills;
- empathy;
- robust, assertive personality;
- independence;
- reliability.

Monitoring

41 When deemed necessary by the peer supporter, and in consultation with the uniformed worker, the peer supporter will advise to seek professional help. The peer supporter can make use of the points of attention listed in recommendation 50.

42 The project group does not recommend the use of existing clinical screening within peer support to 'clinically keep score of complaints'; screening lists can only be used as a diagnostic instrument by professional caregivers. However, when used as topic lists (topics for discussion) the screening lists can serve as a basis during a peer support interview.

43 The project group recommends that supervisors have a certain level of knowledge and skills for the detection of psychosocial problems in uniformed workers after shocking events. This knowledge and skill level at least encompasses the following aspects:

- knowledge of the effects of experiencing a traumatic effect on people and their social context;
- skills for the early detection of psychosocial problems;
- knowledge of the course of the recovery process;
- knowledge of factors influencing the recovery process;
- knowledge of the possible (temporary) consequences on functioning;
- knowledge of what actions to take in the event of trauma-related absenteeism;
- knowledge of practical and social support;
- knowledge of the use of and possible need for adjustments in work activities;
- knowledge of the provisions for (professional) care within the USO;
- skills in supporting the uniformed worker;
- knowledge of the tasks, organisation and working method of organised peer support and the way in which peer support is initiated;
- in the event of psychosocial problems, relevant skills to motivate the uniformed worker to seek expert support.

44 The supervisor must take into account the negative side-effects of incidents and post-studies (including assessment studies), such as internal research, media attention, etc. This aspect should be included when informing and training management, supervisors and members of organised peer support.

45 The project group recommends that detection not only takes place following incidents, but is embedded in daily routine as well.

Responsibilities and assessment of organised peer support

- 46** The project group recommends that the task of coordination, monitoring and assessment of the activities of peer support is embedded and documented within the organisation. Ideally this task is placed with one person.
- 47** The coordination of organised peer support includes the following tasks:
- substantive supervision of peer support;
 - supervision of and responsibility for the quality of the peer support;
 - coaching of peer supporters;
 - facilitation of peer support activities;
 - supporting recruitment for peer support;
 - alignment and maintenance of contacts with other relevant partners in the field;
 - organisation of training of peer supporters;
 - guaranteeing availability of peer support;
 - periodic monitoring and evaluation of the deployment of peer support;
 - periodic reporting on the above aspects within the organisation.
- 48** The project group recommends that privacy regulations are carefully taken into account when a registration system is set up on behalf of peer support. The information on individual persons conveyed within the context of peer support may not be used outside this context.

Deployment of professional care

Indications of need for professional assistance

- 49** In line with the idea of psychological triage, after a shocking event three groups of affected people can be distinguished: 1) people who do not develop complaints; 2) people who *might* develop complaints; and 3) people who demonstrate signals which indicate a disrupted recovery process (and who therefore need to immediately be detected and referred to adequate professional care). Within peer support there must be awareness that the first group (affected persons without complaints) is the largest and that peer support efforts focuses on the last two groups.
- 50** The following indications/signals of a disrupted recovery process should be verbally discussed and reviewed during an interview with organised peer support.
- Having disturbing memories of-, or dreams about the event;
 - getting upset by recurrent memories of the event;
 - having physical stress reactions;
 - avoidance behaviour, absenteeism;
 - having sleeping problems;
 - increased irritability or aggression regulating problems (having a 'short fuse');
 - feelings of unsafety and/or anxiety, being overly alert;
 - having mood swings, sombre mood;
 - having concentration problems;
 - increased alcohol and/or drug use;
 - impairment in functioning (at work and at home);
 - guilt and shame.

- 51** If a uniformed worker, after the shocking event during one of the interviews with the peer supporter shows a disturbing quantity of the above indications/signals, it is best to advise him or her to seek professional assistance. If these symptoms remain four to six weeks after the shocking event, it is certainly recommended to contact professional care with expertise in the area of trauma. Also in the case of doubt the uniformed worker in question should be advised to seek contact with professional care.
- 52** There should not be a 'treatment relationship' between the peer supporter and the uniformed worker.
- 53** The USO must have a protocol relating to referral of uniformed workers to professional care and organised peer support must be informed about this protocol.

Effectiveness of professional care

- 54** The project group advises to make use of existing guidelines and protocols in the area of support and psychosocial after-care (e.g. the guidelines Early Psychosocial Interventions after Disasters, Terrorism and Other Shocking Events (Impact, 2007)).
- 55** The project group believes it is important that the organisation possesses knowledge of the possible treatment methods. Advice with the company doctor, for example, could be sought.

Guidelines

psychosocial support
for uniformed workers
*Extensive summary and
recommendations*

Participating organisations



Ministerie van Defensie



Veiligheidsregio Rotterdam-Rijnmond



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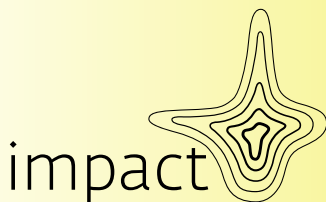
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