Preamble
psychosocial support
for uniformed workers
European guidelines

impact

Colofon

This preambule was co funded by the European Commission - DG Environment, Grant Agreement N° 070401/2009/540414/SUB/A4 - EUTOPA-IP

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Design
Burobraak, Amsterdam

Printed by
Wheel Printing, Katwijk

Publication date
February 2012

This publication can be ordered from Impact, Dutch knowledge- and advice centre for post-disaster psychosocial care.

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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 organisations[2] (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 developed[3]. 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 workers[4]. 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 databases[7] 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 tot 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 general[11] (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 & Haggerty[12] 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 trai-ning/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

[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; Wesseley, 2005; Heslegrave and Colvin 1998.
[16] Sharpley et al., 2008; Deahl et al., 2000.

have a responsibility in preparing employees for potentially shocking events. For example by providing psycho-information[17], 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 employees[18]. 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 Soir[26] 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 literature[38] 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 days[39]. 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 concensus 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 Traumatico (SEPET), Madrid, Spain
- Public Health Department, Düsseldorf, Germany

Participating experts Amsterdam Conference[41]

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Robert Bering	Germany
Hans te Brake	The Netherlands
Bruno Brito	Portugal
Michel Dückers	The Netherlands
Ira Helsloot	The Netherlands (only September 16)
Henriette Hoogendorp	The Netherlands
Leonie Hoijtink	The Netherlands
Eric Geerligs	The Netherlands (discussion leader)
Michaela Krtickova	Czech Republic
Henrik Lyng	Denmark
Josée Netten	The Netherlands
Brigit Nooij	The Netherlands
Lasse Nurmi	Finland
Paco Orengo Garcia	Spain
Ulrich Pasch	Germany
Gerd Puhl	Germany
Don Richardson	Canada
Magda Rooze	The Netherlands
Claudia Schedlich	Germany
Erik de Soir	Belgium
Axel Strang	Germany
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Stephan Vymetal	Czech Republic
Dieter Wagner	Germany
Gisela Zurek	Germany

Experts who could not be present at the conference but answered the questionnair

Name participant	Country
David Alexander	Scotland (United Kingdom)
David E. Alexander	Italy
Irmtraud Beerlage	Germany
Jonathan Bisson	Wales (United Kingdom)
Chris Brewin	United Kingdom
Mark Creamer	Australia
Neil Greenberg	United Kingdom
Mark Walsh	United Kingdom

[41] Die Amsterdamer Konferenz fand am 16. und 17. September 2010 statt.

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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).

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