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Responding to trauma in policing

A practical guide

BetterProfessionals for BetterPolicing™

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Contents

Foreword

This guidance, written by Dr Ian Hesketh and Dr Noreen Tehrani, represents a significant step forward in the journey to improve our understanding of how trauma exposure affects those who work in policing. These are incredible people who willingly place their minds in harm's way to protect us. It brings together expertise from across the field to provide evidence-based guidance which can be applied, in a very practical sense, on the ground.

We need to do much more if we are to instil the confidence in our people that we care deeply about their mental health. We are listening to their lived experiences and we are moving from talking to doing.

If you think that guidance in trauma is the territory of the specialist, and you are about to delegate the application of the models contained within here, I urge you to think again.

Why do I make such a strong appeal?

Firstly, it is everyone's job to commit to developing the necessary self-awareness that is our greatest asset in preventing escalation. Nobody should know you as well as you know yourself. Being able to spot the signs in yourself also helps you spot the signs in others you work with. As a leader or line manager, you can lead by example and inspire others to embark on a deeper personal development journey with many positive benefits.

Secondly, should we, or someone who cares about us, spot the signs, we need to feel confident that it's OK to say 'I'm not OK' without being judged a failure. This remains a cultural challenge in many Blue Light cultures, and you can play a vital role in changing the attitudes and our 'be strong' mindset. All of this is part and parcel of this guidance. It will only work if it is valued from the top.

Finally, if all this has fallen on deaf ears, then consider the operational case. You will, as many examples tragically prove, experience the risks to the individual, the organisation and the communities we serve when trauma escalates to crisis point. When the public are at their lowest point, they rely on our people to turn up and be compassionate and professional in their hour of need. We can only do this if our own organisations treat us with compassion.

Chief Constable Andy Rhodes
NPCC National Lead – Wellbeing & Engagement

Background

Faced with periods of sustained change and cuts in resources, UK police need to manage a rising volume of demands. At the same time, they handle increasingly complex and emotionally demanding tasks in circumstances where the numbers of officers and staff have been dramatically reduced. In parallel with these structural changes, there have also been significant changes in the policing role. These require police officers and staff to take on what in the past would have been regarded as a social welfare role, while still being expected to deliver their traditional policing functions and activities.

Police inhabit a world in which their safety and success requires them to be constantly alert and attentive to the smallest indication of a hazardous situation or an important piece of evidence. These demands can lead to a chronic state of hyperarousal. The pressure to remain constantly vigilant and engaged, while challenging and exciting, can lead to psychological exhaustion and burnout if not managed correctly.

This guidance acknowledges these changes and examines some of the approaches, processes and mechanisms which can help police officers and staff retain their job satisfaction while ensuring that they are adequately protected and supported in maintaining their physical, psychological and social wellbeing.

Organisationally, there are significant changes taking place to the way policing is being delivered in terms of its structures, targets and service delivery. These radical changes are being brought about by the need for forces to continually improve their performance, while at the same time experiencing decreasing budgets. The speed at which this change is taking place makes most of the adjustments, fine tuning and innovations necessary. The changes are being identified by frontline officers who are subsequently tasked with finding ways to make the new systems and processes work. Furthermore, these changes are not without their own problems. The need for increased efficiency is often at the expense of less defensible but essential time for giving and receiving social support and team engagement.

Changes in pensions, and the need to work longer, are also having an impact. This is particularly true for the frontline officer, for whom physical and mental fitness is critically important to deal with the violence and aggression they are often confronted with.

There has been an exceptional level of social change over the past decade. This has been intensified by the increased use of internet and social media. Sexting, online child abuse, internet radicalisation, money laundering and trafficking have introduced new types of crimes, offenders and victims. Computers and other

forms of technology have dramatically changed the way crimes are reported and recorded using smart phones, CCTV and body cameras.

As police forces are required to be more accountable, there have been moves to introduce evidence-based policing. One of the consequences of this approach can be found in health and wellbeing, where occupational health and human resources are expected to provide valid and reliable information and statistics. These demonstrate the benefits and effectiveness of their systems and procedures. They are used to manage the recruitment, training, development and support of the workforce and meet their duty of care to the officers and staff. The combination of changes taking place has made this a challenging time for everyone in policing to manage, personally and organisationally.

Frameworks for action

Addressing stress and trauma in policing is a complex area. To simplify this, we have created a framework for action. The framework has split the risks and responses into three policing areas. Firstly, we will focus on the largest group in the police population, the officers and staff who provide a first response to incidents and events. These roles regularly expose officers and staff to the scene of murders, suicides, road traffic collisions or sudden death. The second group is the police specialist, the officers and staff who concentrate on a specific specialism, such as dealing with domestic violence, child abuse, counter terrorism, firearms, undercover work and road death investigations. The final group includes those officers and staff who are involved in handling disasters. This involves members of the other two groups, but the magnitude of the traumatic event requires a more tailored response.

For each of the three groups, we will examine three activities that need to be undertaken, each based on best evidence. At the same time, these activities will enhance the evidence base through incorporating information gathered through monitoring and evaluation. The three key activities involve identifying, managing and controlling risk by:

- recognising the direct and indirect psychological risks faced by officers and staff
- identifying and selecting the best approach for reducing the risk and mitigating any impact
- establishing processes for monitoring the impact of the exposure and evaluating the effectiveness of any occupational health and human resource interventions.

Table 1: Framework for action

	1. Response	2. Specialist	3. Disaster management
Risk identification	Line manager's assessment	Role risk assessment	Contingency planning
Selecting approach	Demobilising/ defusing	Screening/ surveillance, trauma therapy	Screen and treat debriefing
Evaluating outcome	Stress/trauma toolkit	Individual reports and management information	Post-incident follow up/ screening

Response policing?

Response officers and police staff, by the nature of their work, have little control over their day-to-day activities. They typically experience periods of high demand and the need to deal with angry and upset members of the public. Often working on their own, response officers and staff need to be self-reliant, having few opportunities for social engagement with colleagues. Most response personnel are on shift work and, as a result, may find that they experience anxiety, depression and burnout caused by a depletion of personal physical and emotional resources and ability to cope. Response officers may also experience primary trauma due to direct exposure to traumatic scenes or events. They may also suffer compassion fatigue created by the emotional labour of dealing with the high expectations of the public in situations where there is conflict or highly emotional or distressed people.

Response officers and staff form the largest group in policing and account for most sickness absence. In 2017, a police workforce report showed that there were 2,358 full-time officers on long-term sick, a further 4,426 on recuperative duties and 4,111 in adjusted/restricted duty posts (Home Office 2017). These figures do not include short and medium-term sickness, sickness, presenteeism (coming to work while unwell) or leaveism (taking annual leave or flexi-time when sick). In the past, sickness absence was mainly caused by physical conditions such as musculoskeletal injuries. Today, however, a high proportion of sickness absence is due to mental health conditions.

The psychological risks faced by response officers and staff

Many studies have examined the psychological risks faced by response officers. Where programmes of screening and surveillance have been undertaken, they have reported increased levels of stress, traumatic stress, compassion fatigue and burnout. These have been brought about by trying to meet the demands placed on response officers. These mental health conditions are illustrated in table 2, together with some of the signs and symptoms that help in their recognition.

Table 2: A guide to mental health conditions

Condition	Signs and symptoms
Anxiety	Feeling restlessness, keyed up or on edge. Difficulty in concentrating, mind going blank and irritability. Muscle tension and becoming easily exhausted.
Depression	Loss of interest in activities, large changes in weight, sleep problems, lethargy or agitation. Lack of energy, feeling worthless, hopeless or guilty. Difficulty in concentration. Suicidal thoughts.
Burnout	Emotional exhaustion: feeling emotionally drained and washed out. Depersonalisation: not willing to engage with the difficulties faced by others. Loss of self-esteem: feeling hopeless, useless and incompetent.
Compassion fatigue	Like burnout, but with an increase in emotionality and difficulties in making decisions or concentrating. A loss of self-esteem and trust in others and an increasingly negative outlook on life.
Primary trauma	**Re-experience:** intrusive memories, nightmares, flashbacks, intense distress to reminders. **Avoidance:** avoiding people, places or activities associated with the trauma. **Arousal:** Irritability, self-destructive or recklessness, jumpy, hyperalert, unable to concentrate or relax. **Negative thinking:** lapses in memory, self-blame, negative thoughts and emotions. Loss of interest in activities and an inability to experience positive emotions.
Secondary trauma	Similar symptoms to primary trauma but without the need for a direct exposure to a traumatic incident. Caused by exposure to victims, families, statements or artefacts related to a trauma.

One of the first actions a line manager can take when a team member appears to be struggling is to undertake a stress risk assessment.

Stress risk assessments

The Health and Safety Executive (HSE) stress management guidelines provide a starting point for examining six major stress hazards that can be found in all workplaces (HSE 2008). There are several stress risk assessment tools on the HSE website which help identify the six major stress hazards. Line managers can use these tools to help them engage with individuals or the whole team to identify the specific hazards that are causing difficulties. They can then and work with their team to find reasonable solutions to these problems which meet the needs of the individual, the team and the organisation.

The six hazards are:

- **demands** – including workload, work patterns and the work environment
- **control** – how much say an employee has (voice)
- **support** – including adequate resources and line manager encouragement
- **relationships** – exposure to conflictual relationship and unacceptable behaviour
- **roles** – poorly defined or conflicting
- **change** – including managing change and communication.

These hazards, individually or in combination, can cause police officers and staff increased levels of stress, leading to burnout, compassion fatigue, anxiety and depressive disorders. Remember that it is also important to look at the strengths of the individual and response team, as these can help to build resilience and reduce the impact of personal and organisational hazards.

Trauma risk assessments

In addition to the normal pressures of work, response officers also need to deal with traumatic deaths, injuries and other life-threatening and hazardous events during their work. Situational trauma risk assessment tools have been used in many police forces to help identify situations likely to have significant impact on

those involved. A high score on a situational trauma risk assessment should trigger action by the line manager, who should check that the officers or staff involved have the trauma awareness and support needed.

Table 3: Situational trauma risk assessment tool (Tehrani 1997)

Situational factor	Higher impact	Lower impact
Nature of incident	Deliberate or malicious act	Accidental or natural
The scene	Gruesome, bizarre	Natural, unexceptional
The victim	A child or other vulnerable person	A non-vulnerable adult
Nature of injuries/death	Painful, prolonged	Sudden death or no external injuries
Role	Carried major responsibility for job	A member of a team
Proximity to the incident	High exposure to the scene	Low exposure to the scene
Could it reoccur?	High likelihood of reoccurrence	Unlikely to reoccur
Suddenness	Unexpected	Anticipated
Media attention	High level of media coverage	No media interest
Organisational support	Perceived poor support	Demonstration of concern

Police officers and staff need to be able to deal with a variety of demanding events, often with little preparation. The more calculated and deliberate a criminal act, the more distressing it can be, particularly if the victim is a child, innocent or vulnerable. The sight of a gruesome murder or an unexpected twist to an incident can stick in the mind and be the source of nightmares or flashbacks. The weight of carrying responsibility for others, be they colleagues or members of the public, can create feelings of guilt or shame if things go wrong. Knowing that the incident or event could happen again makes it more difficult to bear. Most officers will mentally prepare for events, but often things happen with no warning and there is no time to consider what would be the best action to take. Finally, the media and a lack of organisational support can make everything much worse.

Approaches to reduce risks and mitigate the impact of stress and trauma

Team leaders and supervisors are critical to improving the wellbeing of their teams. Teams that are well led and functioning have been shown to be more resilient and able to deal with higher levels of stress and trauma. There are differences in the way that stress and trauma need to be handled in the team.

Stress interventions

The HSE has provided some excellent guidance for managers and organisations in how to deal with work-related stress (HSE 2008). The stress management audit tool is a good starting place, where the main problem is the volume of work, workflow, working relationships, organisational change or lack of clarity of purpose. Most of the actions suggested by the HSE in their guide on tackling work-related stress are obvious, however, they require the supervisor to engage with their team members to identify the cause of the problems and to find ways to reduce or resolve difficulties. This process requires the supervisor to have a wide range of personal skills. Interestingly, the skills are not dissimilar to those one would expect to find in a good police investigator, including:

- making observations
- seeking evidence
- thinking creatively
- challenging experts
- decision making
- providing care.

The problem-solving process, which is central to reducing organisational stress requires the supervisor to:

- **Clarify the problem:** What is the issue? When does it happen? What does it affect? When does it not happen? Does it affect others?

- **Identify a preferred outcome:** What do you want? What would that look like? How would it benefit you? Who else might be pleased? What might you lose if you get it?
- **Action plan:** What are you going to do? When are you going to do it? Who could help you? What might get in the way – how would you solve this?

Any stress reduction plans are better if they meet the **SMART** objectives, with **S**pecified outcomes, clear **M**easures of success, **A**chievable steps, where its success would be rewarding and **R**elevant to the problem with a clear **T**ime-table for completion.

Trauma interventions

Reactions to trauma are different to those found in stress. It is important that responding officers are aware of the nature of trauma and the signs and symptoms that indicate that their 'trauma fuse' has blown. Initially, the symptoms of trauma, such as becoming hyper-alert, jumpy, not wanting to eat, avoiding people or places or feeling upset and sad are natural and common responses which will diminish in a few days. If symptoms persist for a longer time, however, this indicates that further support is required. From a supervisory point of view, it is important to cultivate a climate in which it is permitted. This climate should openly encourage officers and staff to talk about responses to distressing or traumatic events. Supervisors also need to be aware of the kinds of jobs that are traumatic and if any of their team are particularly vulnerable. This vulnerability could be due to lack of experience or personal issues.

The situational trauma risk assessment tool (table 3) can be helpful in the assessment. Where there has been exposure to an incident that scores highly, there should be a demobilisation phase. During this phase, the supervisor should acknowledge what has happened, provide some encouragement and support and, when appropriate, offer to meet with the officer or staff member. Supervisors should also be able to undertake defusing, which provides an opportunity for the officer or staff member to talk about what has happened and for the supervisor to check on their physical, emotional, social and psychological wellbeing. Where there is no improvement, a referral should be made for a critical incident debriefing.

Monitoring and evaluating interventions

It is important that all psychological responses and interventions to stress and trauma are followed up. This does not have to place a major administrative burden on supervisors, but a note should be taken whenever an officer or member

of police staff reports these adverse reactions. Where the HSE stress assessment tool has been used, it would be good practice to run it again to check if the responses have been beneficial. It is necessary to evaluate the effectiveness of any debriefing and ensure that the trauma-exposed officers and staff are improving. Where there are still significant symptoms of trauma a month following a traumatic exposure, a referral for trauma therapy should be considered.

Police officers and staff are often nervous about asking for help in dealing with stress and trauma, particularly if this could lead to them being taken off a role they enjoy. However, it is inevitable that stressful situations and traumatic incidents will occur. It is important to recognise that these may not be viewed, felt or experienced in the same way by everyone. Planning should take place to deal with differences in responses. In policing, there is a cultural tendency to downplay personal danger and distress and it is essential to address this. Without openness and acceptance of the reality, stress and trauma will be the cause of sickness absence in policing. Further, there will be a continuing trail of psychologically damaged officers and staff. On a more positive note, developing teams where stress and trauma are openly discussed can create increased opportunities for building resilience and learning.

Working in a specialist police role

This part looks at the challenges faced by officers and staff working in specialist roles in terms of their traumatic exposure and the need for psychological risk management. Historically, there had been two career paths for police officers – those who remained in uniform and those who became detectives. For many, and somewhat controversially, the role of detective was viewed as more prestigious than uniformed roles. For many officers, becoming a detective no longer holds the same level of attraction as it did in the past. In recent times there have been significant changes to the detective's role, leading to a situation where, for some detectives, their work involves little or no 'detecting.' Perhaps unsurprisingly, these changes have been accompanied by a fall in the level of interest in applying for detective roles. This has resulted in some forces proactively seeking detectives internally and advertising to transfer detectives from other forces.

There is also an apparent increase in the practice of appointing officers (and staff) on restricted, recuperative and adjusted duties to detective roles. Furthermore, there has been a propensity to break down the detective role into its constituent elements and to use staff or uniformed officers to carry out many of the tasks. Although this process of deconstructing the detective role has been welcomed by many, who jump at the opportunity to undertake challenging specialist roles,

some of these specialist roles present a considerable mental challenge to even the most resilient of police officers and staff.

The main difference between the hazards faced by response and specialist teams is the predictability of exposure. The specialist role involves a single type of trauma, such as viewing thousands of images of child abuse or constantly dealing with grieving families. It is this continual exposure that creates an environment in which burnout, compassion fatigue and secondary trauma become more likely.

Identifying the high-risk specialist roles

Some of the most psychologically challenging roles in policing include those dealing with child protection, domestic violence and family liaison. Other specialist roles are emerging with the development of technology, with computer science experts pitting their wits against online criminals dealing in fraud, drugs, guns, terrorism and child abuse. With this increasing complexity of crime, there has been a need to develop groups of highly specialised teams of officers and staff. These demands enhance traditional functions, such as those in public protection, counter terrorism, collision investigation, scene of crimes, undercover, forensic examiners and coroner's officers. In addition to these dedicated officers and staff, there are many part-time specialisms, such as family liaison, negotiators and body recovery. These specialist roles carry with them a higher level of psychological risk.

Specialist roles can expose the officers to extreme trauma through direct exposure, as found in a scene of crimes officer, where the work can be intense and concentrated, with few breaks to allow time for recovery. It is also possible to be exposed to secondary trauma caused by exposure to the testimony, images or stories of victims and perpetrators. The symptoms of secondary trauma are similar to primary trauma, but are created by the officer or staff member's ability to empathise with the victim. They can imagine how they or people close to them may be affected, should they experience a similar event.

Several police forces have introduced role risk assessments for these high-risk specialist roles. The role risk assessment is similar to the situational risk assessment but, rather than assessing an incident, is designed to look at the common hazards found in the specific high-risk roles. Over time, a level of consensus has been established between the forces on which roles pose the greatest risks to the role holders.

Identifying the at-risk officers and staff in specialist roles

Once a team has been identified as being at high risk of psychological harm, the most effective way to analyse and evaluate the level of psychological risk experienced by specialist officers and staff is through psychological screening. This is more complicated than using an off-the-shelf survey from the internet, however, or creating your own questionnaires. To be effective, psychological screening needs to use valid and reliable questionnaires which have norms created with working populations. There are three types of screening tool. The first provides a comprehensive assessment of an individual's background, clinical scores, coping and resilience skills. The second checks the ongoing clinical wellbeing, lifestyle and resilience. The third is used when problems have occurred and there is a need to check clinical and organisational wellbeing, lifestyle and resilience skills.

Initial screening

The initial screening of police officers and staff needs to identify whether the individual might be harmed by working in a specialist role. This means that there should be a measurement of their current psychological wellbeing in terms of any symptoms of anxiety, depression, primary or secondary trauma. In addition, there should also be measures of personality, coping skills and style, and resilience. Research has also shown that early life exposures (ACE) to trauma can create additional vulnerability. The initial screening questionnaires are important as they provide a benchmark against which subsequent screening can be measured.

Ongoing screening

The ongoing screening includes all the clinical measures from the initial screening, but adds questions on sickness absence, exposure to trauma, attitudes to health and experiences of the working environment. This questionnaire also looks at personal stressors such as bereavement, relationship issues, physical ill health, financial difficulties and problems at work.

Referral screening

The referral questionnaire is used for individuals who are struggling at work. It is used where additional occupational, behavioural styles and beliefs can be measured to make it easier for the assessor to identify the most appropriate

intervention to help them regain their health. It is important to recognise that even the most robust person can suddenly find themselves having difficulties. This could be due to unrecognised compassion fatigue or burnout, or perhaps a change in personal circumstances. It is essential that referrals can be made in a supportive atmosphere where there is an expectation of recovery.

The results of the psychological screening should allow those taking part to be allocated to one of three groups.

- those who are fit
- those who would benefit from some wellbeing advice or general counselling
- those who require some form of trauma intervention.

In response to these psychological risks, most police forces have introduced additional psychological support for their high-risk specialist roles. The level of psychological support in forces ranges from a simple annual meeting with a welfare officer or counsellor, to a comprehensive programme of psychological screening, surveillance and support. These programmes test levels of anxiety, depression, burnout, primary and secondary trauma as well as their coping skills, resilience and personality. Those who are found to be experiencing difficulties are referred for further assessment and support. This does not occur in all forces, however, leaving those forces with lower levels of support vulnerable to challenge. Not only does this lack of effective support leave the officers and staff with undetected mental health problems, but increasingly leaves the force exposed to criticism by the HMICFRS, the courts or employment tribunals.

Screening programmes are not only useful for individuals, they also provide management with the individual and strategic information they need to identify how the specialist teams are handling their work and whether clinical interventions, training or other changes have had an impact. Anonymised management information on the proportion of officers and staff experiencing clinical-level symptoms is essential if the force is to take a proactive approach to managing wellbeing.

Reducing the impact of primary and secondary trauma in specialist roles

Forces need to recognise that even the strongest person will have physical and emotional limitations. Ignoring these limits can reduce the vigour, engagement and dedication of officers and staff. Maintaining their alignment to the framework for action can help forces reduce psychological harm, maintain discretionary effort and enhance effectiveness. Workability, a measure of how fit and capable people feel they are going to be in the future, is being used to look at the impact of aging and tenure on future wellbeing. There is a need to acknowledge that being subjected to long-term psychological risks can be harmful. From the very outset, it is important to have an exit plan for specialist roles. This exit plan needs to recognise the contribution and acknowledge that many of these specialist roles should involve a period of tenure. Those who leave the specialist roles need to be allowed to go in a dignified manner, with the opportunity to progress into a different role within the force. This exit point should not wait until the individual is failing, but rather take place at a time when they can move forward to other challenges, taking with them all the skills they have developed in their specialism. Recent research has shown that there may be a need to introduce tenure into some of these specialist roles.

Where the surveillance programme identifies significant signs of primary or secondary trauma, forces need to be able to provide a fast track to short-term trauma therapy. This may be delivered by internal police counsellors or by external specialist counselling organisations. The therapy should be trauma-focussed, with the use of therapeutic models which have a strong evidence base of success with emergency service personnel. The two most popular models are trauma-focussed cognitive behavioural therapy (TF CBT) and eye movement desensitisation and reprocessing (EMDR).

Monitoring and evaluating interventions

The screening and surveillance programme is a powerful tool for monitoring and evaluating interventions. Not only does the data it generates provide information for individuals in managing their own health and wellbeing, it also provides information on the wellbeing of teams and the force. There are opportunities for benchmarking in forces and with other forces using similar tools and techniques. The surveillance data base can also be consulted to identify which resilience factors and hazards are affecting psychological wellbeing

and how this information can be used to inform recruitment, identify training needs and to develop supportive seminars. The data may also identify hot-spots where management action needs to be taken to respond to excessive demands, destructive systems or unhelpful management styles.

The trauma therapy programmes should also be audited and evaluated, as trauma therapy is expensive, needing the employment of a cost-benefit analysis to demonstrate value for money. The evaluation of the trauma therapy programme should include improvements in the clinical scores for anxiety, depression, primary and secondary trauma, as well as lifestyle and resilience.

Ultimately, policing is attempting to keep pace with the increasing complexity of demands placed on it. The need is for a smart workforce, comfortable in dealing with uncertainty and complexity, as well as the need to increase technical skills and emotional intelligence. The pressure to undertake specialist skills creates an increased need to develop high levels of resilience. This is a critical aspect if these specialist roles are to be carried out safely.

Disaster management

This final section considers a range of disasters that will affect police forces from time to time. These events include:

- **natural disasters** such as floods resulting in displaced communities, damaged infrastructure and multiple drownings
- **transport disasters** involving aircraft, trains, or road traffic collisions with many casualties
- **major fires** involving large-scale destruction of property and employment, together with the loss of life
- **technological failures** leading to chemical or radioactive contamination
- **terrorist and major criminal activity**, including suicide bombings, marauding terrorists, acid attacks and other terror activities.

The UK has experienced most of these disastrous events during the past year (2017), triggering the need for major policing responses throughout the country. This section explores what can and should be done in response to these disasters, while ensuring that those involved are supported and provided with appropriate advice and guidance.

What we suggest is to build resilience by creating structures which will enable forces to use their contingency planning expertise to build enhanced systems of psychological support. This will allow forces to draw assistance from each other as a means of sharing disaster management awareness and increasing operational resilience. It should not be underestimated that the involvement in dealing with a disaster has a major impact on all those involved. Furthermore, the impact can be long-term and potentially life-changing for many of those directly involved.

There is no commonly accepted definition of a disaster. The Civil Contingency Act describes a civil emergency as an event that threatens public welfare and security. Whenever a civil emergency is declared, emergency powers are handed to the police and other emergency services, local authorities and the NHS. Supporting police officers and staff during a civil emergency can create a significant challenge to policing organisations. The needs of the responders must be balanced with the need to protect the safety and security of the public. It is often said, in acknowledgement of the bravery and sense of public duty, that the police run towards what the majority are running away from. When faced with a major disaster, where there have been multiple deaths and injuries, it is vital to provide effective and efficient support to those involved in responding. It is also important to ensure, as far as possible, that responders can remain operational to deal with the crisis or disaster and handle the aftermath, which can ensue for a considerably longer period.

Forces have a statutory duty to prepare comprehensive emergency plans to work with other emergency services and agencies to protect the public. It is equally important that they have other, parallel plans, however, designed to support the health and wellbeing of their own staff and officers. As with our earlier approach, we will be using a health and safety framework to structure the required responses.

The psychological risks of dealing with a major disaster

Each disaster is unique and carries with it its own physical and psychological hazards. Typically, the first responders at a disaster will be frontline uniformed officers and staff. While working to keep members of the public safe, the lives of these initial responders can be placed at significant risk as they work to rescue the survivors, treat the injured, protect the scene, recover bodies and deal with bystanders, families, friends and members of the public. In large disasters, there can be several hundred police officers involved, dealing with the immediate incident and its aftermath. The business-as-usual trauma responses described earlier are unlikely to be adequate in these circumstances,

particularly where the initial trauma response is reliant on local arrangements, such as in-house peer debriefs.

In a large disaster, the primary role of the responder is to take part in the emergency response and not to provide psychological support to colleagues. Police forces should plan for disasters by building up partnerships with other forces and agencies to provide mutual aid. This will require planning, however, and the need is to adopt and practice the same early intervention models and monitoring we have previously described. Mutual aid exercises are invaluable to those taking part in providing critical resources. Testing systems and providing opportunities for trauma practitioners to gain first-hand experience in dealing with (simulated) disasters is vital.

Identifying officers and staff affected by disasters

Even with mutual aid, the numbers of responders requiring support may make it necessary to adopt a programme of **screen and treat**, rather than offering the same level of support to everyone regardless of need. In screen and treat, all those involved in the disaster will go through a psychological screening process which will identify and prioritise those at greatest risk. Assessing the impact of physical hazards will have precedence over psychological hazards, with the most important intervention being to examine responders for physical injuries. These could be caused by explosions, toxic chemicals or biological hazards found in ingested dust, fumes or materials which may create a risk to life if not identified and treated. Screening for psychological injury can often be undertaken at the same time. The triage screen and treat process requires suitable accommodation and equipment, and trained practitioners, all of which should be identified during the planning and testing (simulation) phase of a response to a major incident.

Post-disaster interventions

Post-disaster trauma interventions in emergency services involve interventions taken from the specialist and emergency responder programmes described earlier in this guidance. Further consideration needs to be given to how the quality of the services can be maintained, however, at a time when resources are stretched and needs intensified. In occupational health, the standard referrals and programmes of support may need to be reduced or stopped

to allow urgent post-incident care. Many police forces have introduced early psychological interventions to help their emergency responders deal with the impact of their experiences. These are typically trauma-focussed and enable all those involved in dealing with the disaster to get together with peers.

The first step takes place as the responder leaves the scene of the disaster, or at the end of the shift. This requires the emergency responders to meet with an officer or staff member identified as having the necessary skills, and designated to be responsible for their wellbeing. Best practice suggests that the identified staff member or officer should thank the responders for their actions in dealing with the incident and provide them with updates on the status of the disaster and on any injured colleagues. During this brief session, the staff member or officer should remind the responder of the potential impact of dealing with trauma, how these symptoms can be handled and how to access additional support.

The second step provides a response for a team or individual having difficulties in dealing with the impact of the disaster. This session should be organised by a trained team leader or supervisor and provide an opportunity for the team or individual to talk about their recollections of the disaster. This ought to be done in a way that helps them create a greater understanding of the timings, events and circumstances of the disaster, as well as help them make some sense of their experiences. The leader should check on the physical, social, emotional and psychological wellbeing of the responder and offer simple lifestyle support and guidance. Where the leader is concerned about an individual or team, a referral should be made to occupational health.

Monitoring and evaluating post-disaster interventions

Keeping track of responders who have been directly or indirectly involved is difficult during a disaster, when systems are frequently overloaded. The more prepared emergency services are for dealing with disasters, the better their systems for monitoring their responders will be. Also, the better the systems are in place for reporting early interventions, the more likely there will be accurate records for evaluating the effectiveness of the programme of psychosocial support for responders thereafter. The evaluation of the British Transport Police's responses to the 7/7 bombing in London provides some valuable insights. It is essential that some thought is given to data collection when forces are developing their emergency planning for dealing with civil contingencies. Subsequently, this helps identify ways that the selection, training, deployment and support of officers and staff affects their resilience in dealing with disasters.

Conclusions

In this guidance, we have offered some insights into ways to protect the health and wellbeing of police officers and staff. We have broken these insights down into three areas to help the reader consider how these principles could be developed and adopted in different police settings and forces:

- generalist
- specialist
- disaster.

We have discussed general issues that affect all who work in the policing environment, with illustrations on how these principles can operate in practice. The psychological risks of secondary trauma and compassion fatigue found in specialist roles has been described, together with the importance of proactive leadership and noticing when others may be struggling. Finally, our focus has been on responding to disasters and the actions that can be taken to help each other through these difficult and life-changing times.

We now want to turn to the future. What do we see as the needs of the service in taking things forward? Psychological screening and support is beginning to yield vital objective information on the risk factors involved in the development and sustaining of psychological distress. It also gathers information on the salutogenic factors which focus on ways to support human health and wellbeing rather than on the things that cause disease. This change of focus can help build resilience and increase the likelihood of learning and growing, through successfully dealing with traumatising events. To achieve our goal, however, we will need to build a body of reliable evidence to help police forces identify what are the critical features of this resilience-building approach. This is critical in terms of the choice of early interventions, including debriefing and psychological first aid. We need to identify the early interventions that are most effective in building resilience as opposed to those designed to treat clinical symptoms. We are constantly engaged with a broad range of partners to see if we can find means to identify the best way to maintain psychological wellbeing in difficult, demanding and traumatic situations. We research and evaluate many existing models of support through a network of practice. We also seek new and innovative approaches with a view to building on technological advancements and innovation to create new and effective methods tailored for the unique world of emergency responders.

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We're the professional body for everyone who works for the police service in England and Wales. Our purpose is to provide those working in policing with the skills and knowledge necessary to prevent crime, protect the public and secure public trust.

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