Abstract

This article will review available literature regarding Post Traumatic Stress Disorder (PTSD) within policing in England and Wales, with a particular focus on its early identification and prevention. An overview of PTSD will be given as well as an exploration of why police officers are potentially more susceptible to this mental health condition compared to other members of society. Key factors in the early identification and prevention of PTSD will be outlined, with a focus on crisis intervention techniques which have been subject to considerable academic study. There is limited research available from England and Wales that looks specifically at PTSD in policing, this research deficit will be highlighted and key areas of research which need to be explored further will be given so that this problem can be both identified and prevented in officers.

Key words: policing, post-traumatic stress disorder, mental health, prevention

Introduction

Most people will experience at least one traumatic event in their lives (Ogle et al., 2013; Horn et al., 2016) and although these events may cause some initial upset and distress, in most cases these conditions will be short lived and the person will recover of their own accord (Litz et al., 2002; NICE, 2005). The issue of PTSD is particularly pertinent to policing as the role of a police officer differs from most other occupations, as the nature of their work means that they are likely to be exposed to multiple sudden and unexpected potentially traumatic events (PTEs) within their career (Ainsworth, 2002; Becker et al., 2009). Whilst this exposure can be perceived as an occupational

hazard (Tuckey and Scott, 2013), this frequent exposure can lead to significant mental health problems such as depression and in some cases PTSD (Greenberg et al., 2015).

PTSD is defined in the National Institute for Health and Care Excellence guidance as a mental health condition that can develop following '*a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone*' (NICE, 2005, p.7). Ellrich and Baier (2017), describe that PTSD can be summarised into four main clusters of symptoms. These can include (i) intrusion (involuntarily re-experiencing the traumatic event through flashbacks or nightmares); (ii) avoidance (of any reminder of the trauma, whether that be an individual, place or particular circumstance such as avoiding going to work); (iii) hyperarousal (including perception of threat, irritability, difficulty in concentrating and sleeping problems) and (iv) emotional numbing (lack of feelings or interest and detachment). To be diagnosed with PTSD a person must have symptoms that affect their daily ability to function normally. It is accepted that symptoms can occur almost immediately, yet an official diagnosis of PTSD will not be made for at least one month, to allow a period of 'watch and wait' to occur. This period of time prior to formal diagnosis acknowledges that the majority of people will recover from the initial trauma experienced without the need for clinical intervention (NICE, 2005; Greenberg et al., 2015). After a traumatic experience most people will show signs of an acute stress reaction but about 1 in 3 of these people will go on to develop PTSD (Royal College of Psychiatrists, 2017). There does not seem to be published figures on the number of people in England and Wales with PTSD, but in a large scale US study, prevalence was found to be 7.8% (women 10.4%, men 5.0%) (Kessler et al., 1995). Although rape

is associated with the highest levels of PTSD (Kessler et al., 1995), there are other contributors that are highly relevant to work as a police officer such as physical attack, being threatened with a weapon and witnessing death or injury (Kessler et al., 1995). Despite investigation into professional exposure to traumatic incidents of other professions (Bender et al., 2016) there is little similar study on police officers in England and Wales. The frequency and severity of the trauma witnessed by police officers make them especially prone to developing mental health problems, Hartley et al. (2013) found that 60.1% of male and 46.4% of female serving police officers reported a traumatic event in the last month. This study also showed very high levels of PTSD in the officers included in the study with a prevalence of 15% for male officers and 18% in the female officers. Canada have been proactive in their support of officers who experience traumatic events, recognising that more police officers kill themselves in Canada than are killed in the line of duty (Badge of Life, 2017). Although there have been some more general attempts to support police officers who suffer from stress in the line of duty, such as the Blue Light Programme run by Mind (Mind, 2017), there is little systematic and national support for police officers with PTSD.

Hayday, et al. (2007) identify that mental health problems are a major factor in long term sickness and absence, and a Freedom of Information Act (FOIA) request on sickness within the Metropolitan Police Service, shows that in the last 3 years there has been a steady increase in police officer illness due to 'psychological disorders'. In financial year 2014-15 there were 39,234 working days lost; in financial year 2015-16 there were 44,012 working days lost; and in the eight months of the 2016-17 financial year (1st April – 31st November 2016), there were already 38,792 working days lost to psychological disorders (MPS, 2017). If left unrecognised, undiagnosed or untreated,

mental health problems can have significant health effects, which can lead to relationship and work problems, including an inability to effectively perform their role (Ainsworth, 2002), and in extreme cases can also lead to an increased risk of suicide (Marshall et al., 2001; Chae and Boyle, 2013).

A further complication is that there are significant cultural issues within policing that can act as a barrier to seeking help, which means that police officers are more likely to hide their trauma than other groups within society (Becker et al., 2009; Heffren and Hausdorf, 2016). These barriers can include a fear of appearing weak, a fear of a breach of confidentiality, and that seeking help will harm their careers (Greenberg et al., 2005; Skogstad et al., 2013; Ellrich and Baier, 2017). However, whether police officers actively seek help and support for themselves or not, there is clearly a moral, ethical and legal duty to ensure that an officers' health and wellbeing is looked after, as we are asking police officers to undertake some of the most challenging and unpleasant tasks on behalf of the rest of society (Walsh et al., 2013).

In sum, it is clear that the nature of police work is at times challenging and traumatic, so the elimination of PTSD is unlikely to ever be fully achieved. However, there is a need to minimise the effects of trauma wherever possible in order to 'protect the protectors'. The duty of care, must extend to those required to continually engage in dangerous, stressful and even life threatening duties on a regular basis.

Early identification and prevention of PTSD

Part of the challenge in the prevention of PTSD is in the difficultly of identifying beforehand those who are likely to be affected after a traumatic event, although

Halligan and Yehuda (2000) observe that exposure to a previous incident can lead to PTSD after a further traumatic event. Identification is additionally complicated by the fact that PTSD symptoms are rarely found alone, which can lead to them being masked by other conditions (Ainsworth, 2002; Shea and Zlotnick, 2002). Although there is a large amount of research on PTSD within society in general there is limited research on the impact on PTSD in policing, which is a specific and nuanced form of the condition. There is a marked difference between people who experience an unexpected traumatic event and people who are exposed to repeated traumas as a result of their profession. The research that does exist on PTSD as a result of occupational trauma, has focused mostly on single incident trauma on fire fighters and military personal with very little focusing on police officers (Skeffington et al., 2013). What research that does exist, although non-specific to police officers strongly supports the need for multiple rather than single interventions such as crisis intervention programmes, when dealing with people who have experienced traumatic events. Crisis intervention programmes aim to prevent the onset of mental health issues through early intervention after a traumatic event, in order to reduce subsequent reactions (Chapin et al., 2008). Crisis interventions can vary, but generally describe a range of techniques such as pre-incident preparedness briefings, education and training (including psychological 'first aid' training for managers); debriefing and counselling (individual, group or joint with family members); the development of staff support groups as well as post incident referral to specialist services if needed (Raphael, 1986; Tehrani, 1995; Everly et al., 1999). Preparation through resilience training and pre and post educational briefings has been shown to be a protective factor when dealing with traumatic events (Marmar et al., 1996; Skeffington et al., 2013). This education prior to exposure is believed to prepare the individual prior to

the trauma, thereby making any symptoms experienced ‘normal’ and less disturbing, as well as making those affected more likely to seek help (Brown and Campbell, 1995; Wessely et al., 2008). Leeman-Conley’s 1990 study of bank workers in Australia (cited in Everly et al., 1999) evidenced that the multiple intervention approach worked with staff who were primary victims of robbery, and reduced staff sickness by 60%. Deahl et al. (2000) demonstrated that an ‘Operational Stress Training Package’ which consisted of PTSD and stress education awareness training, that was given to 106 British soldiers prior to a six-month tour of Bosnia, led to only 3 of the 106 recording ‘clinically significant’ PTSD.

Interventions Post Exposure to Trauma

Empowerment through resilience training is argued by Rutter (2012) and Horn et al. (2016) to be the best way to support staff who have experienced a traumatic event. This empowerment can be through a debriefing process where a structured and supportive conversation through the traumatic event (Tuckey, 2007). The most commonly known psychological critical incident debriefing tool is ‘Critical Incident Stress Debriefing’ (CISD) which was developed by Mitchell in 1983 (cited in Mitchell et al., 2003) in order to support and reduce the onset of symptoms in emergency services personal who have experienced traumatic events. CISD consists of seven key phases followed in sequence. These are an introductory phase (expectations and ground rules are set); the fact phase (where the incident is discussed); the thought phase (meanings and reflection); the reaction phase (emotional responses); the symptoms phase (reactions that are experienced); the education phase (coping strategies and managing reactions) and the re-entry phase (discussions regarding returning to everyday life) (Tuckey, 2007; Tuckery and Scott, 2013). The CISD process

usually occurs between two and seven days post incident and is not usually repeated. It is imperative that properly trained staff are used to limit the potential damage that can be caused by reliving traumatic events, so a mental health professional and an operational 'peer' are used (Everly et al., 1999). The role of the peer in the process is crucial as it has been argued that those suffering from the effects of trauma do not necessarily want to be seen by a medical professional or counsellor (Wessely et al., 2008; Heffren and Hausdorf, 2016), but by someone with whom there is trust, which can be built through a shared knowledge and understanding of the experiences that they have gone through (Shea and Zlotnick, 2002; Karlsson and Christianson, 2003; Hawker et al., 2011**).** Miller (2006) and Adler et al. (2008) both argue that CISD is a popular tool with hierarchical organisations such as policing due to its awareness of organisational culture, lack of stigma attached to its use and the ability to discuss shared experiences to traumatic events.

Any post incident briefing, for example would need to take into consideration, the appropriate time to intervene in a legal sense to ensure that any evidence provided by officers could withstand scrutiny in court. Firstly, any intervention would ideally need to be after the officer has recorded their evidence regarding the incident in contemporaneous form or in statement form. The appropriate practices would need to be adhered to in order to ensure that any evidence provided is untainted by the process of debriefing of the traumatic incident. In most cases, this would not be an issue, where it is made clear that any debriefing relates to welfare not a rehearsal or coaching in relation to potential evidence. In addition, following enactment of the Criminal Procedure and Investigations Act 1996 (CPIA, 1996), the fact of any intervention would need to be revealed to the CPS. Also, any debrief material,

counselling or therapy sessions do not automatically attract confidentiality and may be classified as relevant material required to at least be revealed to the prosecutor for disclosure consideration (CPIA, 1996; Niblett, 1997). This lack of confidentiality, may hinder the effectiveness of the debriefing as officers may be reluctant to be open and honest for fear of ramifications for them professionally or in court.

CISD was designed to be part of a wider package of support mechanisms when dealing with trauma, but appears to have been interpreted by some as a standalone intervention (Mitchell, 2014) which has led to mixed reviews regarding its effectiveness. A Cochrane systematic review of psychological debriefings (Rose et al., 2002) was conducted which was based on an assessment of 15 randomized control trials (RCTs) and gave mixed results. Three of the RCTs had positive outcomes, nine found no effect and two were perceived to have negative outcomes. This review successfully argued that single incident debriefing such as CISD may in fact be harmful although it acknowledged that the review may not be relevant to emergency services and that it did not test or question the effectiveness of group debriefing (Rose et al., 2002; Greenberg et al., 2005). The National Institute for Health and Care Excellence guidelines (NICE, 2005) supported the Cochrane findings by recommending that single incident debriefing should be not be used as it was felt it may cause harm (NICE, 2005). Tuckey (2007) and Hawker et al. (2011) however argue that there are flaws within the numerous reviews of the debriefing process, as most of the critiqued research has involved debriefing people who are not psychologically ready and this being done too soon after the event (within 24 hours, and on occasions whilst they are still in physical pain and psychological distress), the process was not long enough (most were less than an hour) and a number used

untrained practitioners. Critically the two experiments which questioned the effectiveness of CISD (Bisson et al., 1997 and Mayou et al., 2000) were focused on primary victims of trauma, such as burn victims and those injured in road traffic accidents, rather than secondary victims such as emergency responders for whom the process was designed. If the correct process had been followed by qualified practitioners, then they argue that the actual taking away of CISD may be more harmful as it has removed a mechanism for those affected by trauma to discuss what has happened within a trusted and safe environment. Eid et al. (2001) and Jacobs et al., (2004) support the effectiveness of CISD for emergency services personnel. Tuckey and Scott (2013) however acknowledge that whilst there is some evidence that group debriefing may limit the onset of PTSD symptoms through social and peer support, they recommend that there needs to be more research on its effectiveness.

The Importance of Peer Support

The removal of CISD has led to other debriefing tools to be 'rebadged', so that they can be used (Hawker et al., 2011). Support Post Trauma (SPoT) is a crisis intervention program designed to provide organisational support following a traumatic event. It consists of a voluntary meeting held within 3 days with a specially trained manager. The aim is to provide an opportunity to talk about the incident and educate about the symptoms that they may experience as well as signposting to support services (Rick, et al., 2006). Trauma Risk Management (TRiM) is a peer support system that aims to risk assess, provide support and educate staff after a traumatic event. It consists of a risk assessment interview, 3 days post event to assess the trauma, and identify those in immediate need of specialist help (Walsh et al, 2013). TRiM is different to CISD and other psychological debriefing programs as it is voluntary and there is a selection

process to decide who receives this intervention, rather than debriefing all parties who were involved (Hunt et al., 2013). Following the 'NICE' guidelines (NICE, 2005) TRiM allows a month of watchful waiting', and then a follow up assessment is conducted to reassess their symptoms of trauma (Greenberg et al., 2005; Whybrow et al., 2015).

There is considerable academic research that supports that the provision of peer and social support through the mechanism of debriefing (formal or informal) as a strong protective factor in the recovery from trauma and prevention of PTSD, although the role of family support and what constitutes supportive or unsupportive behaviour is less clear (Evans et al., 2013). This may in part be due to the fact that many officers do not want to talk about their experiences with their family through fear of traumatising them, or because they feel that their families may not understand what they have gone through (Brown and Campbell, 1995). There is also the perceived 'macho' culture of not needing to talk and 'just getting on with the job' (Evans et al., 2013). This in part, explains the importance of group debriefing within policing as it provides the opportunity to talk through the traumatic event with others who have experienced similar things and would have a level of understating that would make them less likely to be traumatised by the discussions and more likely to understand what they are going through, particularly if the traumatic event is seen as a shared experience. There is also the benefit that a formal mandatory debriefing process does not carry with it the stigma of formal interventions, which means those involved are more likely to share their experiences without fear of being judged (Forbes and Roger, 1999; Violanti, et al., 2016; Ellrich and Baier, 2017). Dowling et al. (2006) studied the effects of trauma after 11th September 2001 on New York police officers. They found that approximately 34% of those involved were still suffering the effects of trauma. They highlighted the

effectiveness of peer support through the 'Police Organisation Providing Peer Assistance' (POPPA) programme which encouraged talking the sharing of experiences with peers. Stephens and Long (1997), in their study of 527 New Zealand police officers showed that the ability to talk to others within the workplace about traumatic experiences led to fewer PTSD symptoms. Martin et al. (2009), in their study of 132 Canadian police officers, and Tuckey and Hayward (2011) in their study of 547 volunteer fire-fighters in Australia also found that social support from colleagues during a traumatic event was a significant protective factor against the effects of poor psychological health.

The Importance of Organisational Support

Whilst peer support is important to those who have experienced a traumatic event, it is also argued that line managers and supervisors are an important part of any support network as not only are they a source of support to those affected by trauma but they also have the ability to influence team attitudes towards dealing with trauma, reducing stigma and encouraging those in need to seek help (Evans et al., 2013). Everly et al. (1999) and Heffren and Hausdorf (2016), also articulate the importance of supervisors being trained in 'psychological first aid' so that they can not only spot the signs and symptoms of trauma, but ensure that staff are given the time and the support that they need in order to recover in a 'low stress' environment. This may mean moving from their current role, which is supported by Greenberg et al. (2015), but they add that if the person is moved then it is important that the social support is maintained, and they are not left feeling isolated.

In sum, from research shown here it appears that there is no ‘one size fits all’ solution to preventing the onset of PTSD as every individual copes with trauma differently. But, there are a number of potential options to support officers and try to prevent the onset of serious mental health issues such as PTSD through early intervention techniques, which need to be explored further.

Further Recommendations

In addition to importance of peer and organizational support, there is an urgent need for more research and understanding of the issue of PTSD in police officers in England and Wales. There is a deficit of research carried out in England and Wales and so the extent and scope of the problem is not known, although international literature would suggest a very real problem exists. Additionally, a comprehensive, nationwide response is needed to ensure that police officers that are suffering from vicarious trauma, work related stress or PTSD are identified as quickly as possible and receive the help and support they need in an appropriate way. Special attention should be paid to any officers who are known to have experienced a traumatic incident with a high level of severity (such as a terrorist attack or a fire arms incident) as these officers are at especially high risk of developing PTSD (Carlier et al., 1997). Systems for screening for PTSD and offering support to officers should be implemented, based on the current knowledge base drawing on the international literature available. There is also a need for an organizational attitude shift, recognizing that trauma and PTSD are potential professional risks of being a police officer and as such there is a need for easily accessible, stigma free screening and treatment.

Conclusion

PTSD in police officers can not only have a significant impact on the life of the person affected, but also on their loved ones, friends, colleagues and even the public through their inability to effectively carry out their duties, due to the difficulties that they may be experiencing (mood swings or aggressive/violent behaviour).

As a result of the very nature of their work, police officers are more likely to experience sudden and unexpected trauma than society as a whole. Yet there has been little research that has explored PTSD in police officers, with even less focusing on policing in England and Wales, causality or police specific factors that can lead to PTSD, such as the effects of cumulative or 'small t' trauma (for example when officers are exposed to repeated rape and child abuse victims). These are clearly areas for further research.

From the limited evidence available early intervention appears to be key to preventing the onset of PTSD symptoms. These interventions should be multifaceted and consider the inclusion of pre-incident preparation (through education and training), risk assessment or crisis intervention techniques, and ensure that there are strong peer/social support networks available. However, whilst social support appears to be a strong protective factor in PTSD prevention, there were no studies which explored the actual impact of social support by colleagues amongst police officers, which, if so important in this area is clearly another area of further research.

One of the key challenges in policing is to remove the 'stigma' of suffering from mental health issues and there needs to be a change in organisational culture at the 'grass roots' level to drive this change. Policing needs to educate its officers by delivering stress awareness training (or similar) at recruit level and improve the knowledge and

skills of junior managers (Sergeants and Inspectors) through ‘psychological first aid’ training. This will not only allow supervisors to spot potential signs and symptoms of trauma and take the necessary action (particularly during the month long ‘watch and wait’ period), but will also give a greater understanding of mental health to all officers. It is hoped that if this were introduced, it may go some way to normalising mental health issues, and start to remove the stigma associated with seeking help.

A final thought is that if most people in society will experience a traumatic event in their lives and police officers are more likely to be exposed to trauma than most, could it be argued that all officers potentially experience PTSD in their working careers. These symptoms would present on a ‘sliding scale’ of mild to severe, with the resilience, coping mechanisms and social support that they have in place determining their position on that scale at any particular time in their lives.

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