



## The role of psychological screening for emergency service responders

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## The role of psychological screening for emergency service responders

### Abstract

**Purpose:** The purpose of this paper is to examine the role psychological screening and surveillance takes in improving the delivery of psychological support to emergency service responders (ESR) at a time of increasing demands and complexity.

**Approach:** To review the evidence for the psychological screening and surveillance of trauma exposed emergency service workers.

**Findings:** The evidence supports the use of psychological screening and surveillance using appropriate validated questionnaires and surveys.

**Implications:** The findings suggest that emergency services should be using psychological screening and surveillance of ESRs in roles with a high risk of traumatic stress.

**Originality/Value:** These findings will help emergency service organisations recognise how psychological screening and surveillance can be used as part of a wider programme of wellbeing support. This approach can also help them meet their legal Health & Safety obligations to protect the psychological health and wellbeing of their ESRs.

**Key Words:** Emergency Services, Traumatic Stress, Psychological Surveillance, Wellbeing

**Paper Type:** Technical Paper

### Introduction

UK Emergency Services have entered a period of unprecedented change, at a time of reduced budgets (National Audit Office, 2015a and 2015b), reduced manpower (HMIC, 2016), increasing demands (National Audit Office, 2017), and changes to the terms and conditions for their workers (Windsor, 2012; Hutton, 2011). The pace of these changes make organisational and operational adjustment difficult (Windsor, 2012; Simcock, 2015; National Audit Office, 2017). In addition, emergency service responders (ESRs) are dealing with mounting threats from terrorism, natural, and man-made disasters at a level and intensity rarely experienced in the past. There are pressures to increase joint working between emergency services, both strategically (HM Government, 2016) and operationally (ESCWG, 2016), with firefighters, police and paramedics taking over aspects of each other's roles. This move has not been without opposition, with firefighters and police finding the

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3 emotional labour of dealing with health-related emergencies, whilst surrounded by  
4 distressed and grieving families, difficult to handle. In policing, the combination of reduced  
5 resources, increased pressure and complex demands has led to higher levels of sickness  
6 absence (Guardian, 2016) and difficulties in the recruitment and retention of workers  
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8 (National Health Executive, 2015).  
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13 The roles of those working in emergency services fall into three main categories (College of  
14 Policing, 2016). The first category are the frontline responders who are regularly involved in  
15 responding to incidents ranging from recovering stolen bicycles, transporting patients or  
16 checking smoke alarms, to dealing with murder, serious injuries, major fires, domestic  
17 violence, suicides and cot deaths. These same responders are often the first at the scene of  
18 major incidents such as terrorist attacks, rail crashes, riots and explosions. The main  
19 characteristic of traumatic exposure for the front-line responders is the unpredictability of  
20 the incidents they are required to handle. Emergency responders have little time to prepare  
21 to meet the operational and emotional demands of the incident, with the result that their  
22 ability to cope can become overwhelmed. The psychological impact of attempting to meet  
23 extreme physical, cognitive and emotional demands of a crisis can be the development of  
24 acute stress disorder, which may lead to post-traumatic stress (Shakespeare-Finch, 2011;  
25 Halpern et al. 2009).  
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38 The second category of ESRs include those working in roles involving intense exposure to  
39 psychological hazards, these specialists ESRs use their technical skills in high psychological  
40 risk areas of work. In policing these may include on-line child abuse, domestic violence,  
41 firearms, undercover work, accident investigations or family liaison. In these specialist roles  
42 the psychological risks are inherent to the role, creating a responsibility on the organisation  
43 to meet its legal duty of care to protect the wellbeing of these workers. This duty requires  
44 the emergency service to have plans and procedures in place to identify, monitor, reduce  
45 and respond to psychological hazards (Management of Health and Safety Regulations,  
46 1999). ESRs working in specialist roles may experience a build-up of compassion fatigue and  
47 secondary trauma, which can go unnoticed, unrecognised and untreated, until the ESR finds  
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3 themselves unable to cope due to the long term psychological harm caused by their work  
4 (Weiss et al. 2010).  
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8 The third category is made up of response and specialist ESR deployed to deal with a major  
9 disaster. Emergency services are well versed in handling the operational and practical  
10 challenges of major fires, floods, transport collisions and terrorist attacks involving mass  
11 death and casualties (Slottie et al. 2008). Comprehensive emergency preparedness  
12 guidance (Cabinet Office, 2012) sets the framework for civil protection dealing with  
13 preparation, management and prevention of emergencies. However, emergency services  
14 are less well prepared for dealing with the human impact of a disaster on their ESRs who are  
15 involved in disaster responses. Whilst most ESRs will handle the psychological impact of  
16 dealing with the demands of a major disaster, many will become affected, at least in the  
17 short term (Tehrani, 2016).  
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27 This paper has four aims:

- 28 1. To explain how physical and psychological screening and surveillance is used in  
29 organisations;
- 30 2. To provide an outline on meeting the needs of the response, specialist and disaster facing  
31 ESRs;
- 32 3. To describe the range of tools available to be used in screening and surveillance;
- 33 4. To discuss the reasons for introducing psychological screening and surveillance into  
34 emergency services.  
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## 42 **Use of Screening and Surveillance**

43 Health surveillance and screening has been used in emergency services to provide evidence  
44 to assist in the assessment, monitoring and support of ESRs fitness for work. Surveillance  
45 adopts a systematic approach to the early identification of work-related ill-health or injury  
46 (Mouthaan et al. 2014; Dantzker, 2011; Carleton, 2017; McFarlane and Bryant, 2007). The  
47 Management of Health and Safety at Work (1999) legislation provides the framework with a  
48 specific reference to the need for surveillance,  
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3       *“Every employer shall ensure that his employees are provided with such*  
4       *health surveillance as is appropriate having regard to the risks to their health*  
5       *and safety which are identified by the assessment.”* (Point 6).  
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8       Surveillance falls within the wider Risk Control and Management Cycle in which  
9       organisations are required by law to identify risks, establish who might be harmed, to  
10       evaluate the magnitude of the risk and to identify ways to mitigate or reduce the risks  
11       (IOSH, 2016). Occupational surveillance shares some of the features of clinical research,  
12       but is not designed to generate or create new scientific knowledge. Rather, it uses existing  
13       knowledge and research to prevent disease or injury, enhance resilience and increase  
14       wellbeing in employees who may become exposed to an identified health hazard (Otto et al.  
15       2014). A review of the risks inherent in organisations (European Agency for Safety and  
16       Health at Work, 2011) identified a range of hazards found in emergency services, including  
17       physical exposures to radioactive, chemical and biological substances in addition to physical  
18       injuries caused by physical violence, needlesticks and injuries caused by knives and firearms.  
19       In addition to the physical hazards, the agency identified several psychological hazards.  
20       These include exposure to disasters, dealing with multiple deaths, body recovery, transport  
21       accidents, terrorism, fires, shootings and other threats to life. Psychometric testing is used  
22       for different purposes, in emergency services tests are often employed in pre-employment  
23       screening to assess a candidate’s fitness to carry out their roles. The College of Policing  
24       (2015) has established standards for pre-employment screening which include an  
25       assessment of physical and psychological fitness, together with tests of aptitude and mental  
26       capacity. ESRs are required to have regular in-post checks of their stamina, sight and hearing  
27       (e.g. College of Policing, 2014).  
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29       The use of screening in psychological surveillance is different to the psychometric testing  
30       that takes place pre-employment, in contrast to the one-off pre-employment tests,  
31       psychological surveillance is an ongoing process used to assist in the maintenance of a  
32       healthy workforce where the results allow for ESRs to be tracked over time, identifying  
33       those with signs or symptoms indicative of actual or imminent psychological difficulties. An  
34       important issue for screening and surveillance programmes is the reliability and validity of  
35       the tools employed (Mouthaan et al. 2014). Psychological tests need to demonstrate that  
36       they accurately measure the magnitude of a psychological condition or feature over time  
37       and population. In addition, these tools need to be able to differentiate between ESRs  
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3 experiencing significant early signs of psychological distress from those within a normal  
4 range of emotional expression. A benefit of a surveillance approach is that it allows for the  
5 sensitivity of the cut-off levels to be adjusted informed by organisational feedback on levels  
6 of sickness absence and occupational health referrals together with the proportion of ESR  
7 referrals deemed appropriate at clinical assessment. The surveillance approach recognises  
8 that mental health is a continuum, where the boundary between coping and not coping  
9 with pressures of emergency work may be very narrow.  
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17 There are some researchers working with the UK military (e.g. Rona et al 2006; Greenberg,  
18 2015) who suggest that pre-employment screening is ineffective in reducing or predicting  
19 PTSD, and that screening can adversely affect the career of those identified as vulnerable  
20 (Jones et al. 2003). This negative view of screening is challenged by US military researchers  
21 (Castro; 2014; Milliken *et al.* 2007), who utilise screening for the early identification of  
22 mental health problems, and in programmes of education and support. In the US screening  
23 is used to increase wellbeing and resilience by reducing psychological stigma and barriers to  
24 seeking support. Wright *et al.* (2007) described psychological screening as one of the most  
25 widely used ways to identify [US] military personnel who might need help for a mental  
26 health issue.  
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## 36 **Meeting the Needs of Emergency Service Responders (ESRs)**

### 37 ***Front-line Responders***

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39 The largest group of ESR are the frontline responders. For this group the nature and  
40 frequency of the traumatic exposure is difficult to predict. However, the types of the  
41 traumatic events causing trauma responses together with the organisational and personal  
42 factors that increase vulnerability are largely understood (Skogstad et al, 2013). As frontline  
43 responders do not face predictable traumatic events it is inappropriate for them to be part  
44 of a surveillance programme, as their results can provide data which can be misleading and  
45 costly (HSE, 1999). Therefore, the responsibility for the psychological wellbeing of frontline  
46 responders falls to their line manager and the ESRs themselves. The line managers of  
47 frontline responders need to be trained in identifying the signs of mental health problems  
48 (including traumatic stress), to have the skills to talk to their team about any personal  
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3 difficulties, personal resilience, and to create an environment where open discussion of  
4 work related problems is seen as a strength rather than a weakness (Hesketh & Cooper,  
5 2017). The frontline responders need comprehensive induction training to prepare them  
6 for the nature of their role and the incidents that may cause a trauma response (Castro et  
7 al, 2006), they also need to be able to recognise symptoms of trauma in themselves and  
8 others. A study undertaken for the Health and Safety Executive by Mitchell & Stevenson  
9 (2000) found that supportive supervisors with a positive management approach, a  
10 workforce educated in the recognition of psychological signs and symptoms, together with  
11 flexible psycho-social support, reduced the likelihood of psychological problems. When a  
12 front-line responder returns from a shift it is important that time is made available for them  
13 to be demobilised by their line manager. The demobilising process takes between 5-10  
14 minutes (Tehrani, 2014). If the team leader recognises that a responder has been seriously  
15 affected by an incident there may be a need to arrange a longer demobilising session, which  
16 provides the responder with an opportunity to talk about the incident that has caused the  
17 difficulty, and to be provided with helpful psycho-education and advice (Tehrani, 2014).  
18 Where responders continue to struggle, their line manager should make a referral to  
19 Occupational Health, who can refer the ESR for psychological screening to identify if there is  
20 a need for a psychological assessment or other supportive intervention. The provision of  
21 organisational demobilisation and defusing following a traumatic incident has been shown  
22 to meet several needs for teams, by providing a) support that is highly valued by workers; b)  
23 an opportunity to identify workers requiring clinical support; c) an increase in level of social  
24 cohesion; d) a reduction in harmful responses e.g. alcohol abuse; e) a reduced levels of sick-  
25 leave; f) increased performance (Creamer et al. 2012).

### ***Specialist Responders***

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46 There is a relatively small group of ESRs, who are employed in roles which continually  
47 expose them to psychologically distressing or demanding conditions. Risk assessments have  
48 identified the roles which carry the highest psychological burden. In Policing, for example,  
49 these include: family liaison, call handling, undercover investigations, public protection,  
50 viewing on-line images of child abuse, firearms, hostage negotiators and body recovery.  
51 Emergency services have to respond to the needs of these ESRs by introducing mandatory  
52 risk assessments, psychological screening and support to meet their duty of care

(Management of Health and Safety Regulations, 1999). Craun et al (2014) undertook research to examine the level of secondary traumatic stress in law enforcement officers involved in the investigation of sex offences, and found that the development of PTSD, secondary trauma and compassion fatigue was reduced where there was positive supervisor support, and increased where there were high levels of denial. Research by Carleton *et al.* (2017) involving the screening of 5813 Canadian ESRs (police, paramedics, firefighters and prison officers) for PTSD, anxiety, depression, social anxiety, panic disorder and alcohol abuse found that there was an indication of at least one of the disorders in 44.5% of the ESRs. Wortley *et al.* (2014) studied internet child abuse investigators. This study used a combination of screening questionnaires and interviews which showed that whilst the majority had no clinically significant symptoms, there were a number experiencing significant levels of PTSD a risk that appeared to increase over time. Whilst these research projects on the psychological impact of the roles undertaken by ESRs provides vital information on the nature of psychological exposure and distress, they should not be confused with psychological surveillance.

The case for a national screening and surveillance programme of workers exposed to traumatic incidents was proposed by Dollard *et al* (2007), who support the use of surveillance for monitoring and tracking how the nature and management of work creates challenges for the occupational health and safety of workers. Essential to the introduction of surveillance programmes is the development of screening tools, with clearly defined cut-off levels which can be used to identify those ESRs needing further psychological support and assessment (McFarlane & Bryant, 2007). The need for psychological surveillance in ESRs was identified in the late 1990s, on-line screening and surveillance for specialist roles has made this more feasible (Price *et al.*, 2016). The surveillance programme measures a range of clinical symptoms, including anxiety, depression, PTSD, burnout and compassion fatigue; with ESRs being screened pre-deployment and at regular intervals throughout their specialist deployment. Initial screening shows that around 80% of ESRs in specialist roles are fit and have no significant symptoms of trauma, 15% have scores which are concerning and 5% have clinically significant symptoms of PTSD (Tehrani, 2016a). The screening results do not halt deployment, but rather they trigger a psychological assessment which can be used to provide psycho-social education and advice, a referral for trauma therapy and occasionally a redeployment to an alternative role (College of Policing, 2018). Surveillance



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3 of child protection officers (Tehrani, 2018) examined the results from 2289 officers and  
4 showed that attitudes to health, tenure and adverse childhood experiences were associated  
5 with increased clinical scores. In another surveillance report involving 126 internet child  
6 abuse investigators (Tehrani, 2016), it was found that there were higher levels of secondary  
7 traumatic stress in female investigators, and in investigators who were introverted or  
8 neurotic. The role of surveillance is not, in itself, to reduce the incidence of mental health  
9 problems. Rather, it is a supportive measure to identify risk and resilience factors within the  
10 working environment, and to identify where and individual ESR requires support or further  
11 assessment. As with the frontline responders, the line manager's role is important in  
12 providing a supportive environment in which it is acceptable for ESRs to discuss their work  
13 and the challenges it creates in personal and working life. The line manager should also  
14 make a referral to occupational health where there is a need for additional assessment and  
15 support.

### ***Disaster Responders***

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28 Large numbers of frontline and specialist ESR are needed to deal with major incidents and  
29 disasters, and depending on their level of exposure, many will require psychological support  
30 (BPS, 2018). As with the frontline responders, it is important to provide immediate practical  
31 support at the time of the disaster, and to ensure that ESRs are demobilised at the end of  
32 each shift. Although debriefing is designed to prevent or treat PTSD (Regel & Dyregrov,  
33 2012; Ruck et al. 2013), these interventions are highly valued in building social cohesion and  
34 support (Dyregrov, 2002). Debriefing meets the needs of ESRs to have their experiences  
35 recognised in a familiar setting, where they can be provided with psycho-education, support  
36 and the opportunity to reflect on their experiences with their colleagues. Although the use  
37 of debriefing has been challenged as a treatment for PTSD (Bisson et al. 2000), this does not  
38 detract from the role debriefing can play in providing an early indication of those requiring  
39 further assessment and support (Arendt & Elklit, 2001).

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There is mounting evidence to show that undertaking brief screening can be helpful in  
identifying ESRs who are likely to require psychological support. It is recognised that in the  
immediate aftermath of a disaster most people will have experienced heightened responses  
(Sijbrandij et al 2008), and that these responses will rapidly decline over time. However, for  
some ESRs the symptoms do not decline, and may become more intense. There has been

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3 some success in developing brief post-trauma screening tools which have a high level of  
4 sensitivity and specificity in accurately identifying people likely to develop PTSD (Brewin et  
5 al 2008; Mouthaan et al 2014). The screen and treat approach has the benefit of identifying  
6 ERSs who need to be referred to occupational health for a more comprehensive screening  
7 and psychological assessment.  
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### 11 12 13 **Screening and Surveillance Tools** 14

15 There is a wide range of psychological questionnaires which can be used to identify levels of  
16 trauma and clinical wellbeing (ACPO, 2007). Table 1 provides a list of some of those  
17 commonly used in the screening and surveillance process. The list of tools has been divided  
18 into four main groups:  
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- 22 a) Critical incident screening tools which involve self-report questionnaires that can be  
23 used after a critical incident as a way of identifying ESR who need to be referred for  
24 further investigation. The sensitivity and specificity of the shorter tools have been  
25 shown to be as good as the longer tools (Sijbrandij et al 2008), therefore it would  
26 seem appropriate to use the shorter tools as these are more likely to be completed.  
27 There is a growing tendency for these questionnaires to be completed on smart-  
28 phones.  
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- 34 b) Clinical assessment tools are also self-report tools and are often completed online  
35 for ease of scoring and analysis. The PCL-5 and PSS-5 are similar, in that they are  
36 based on the latest version of the Diagnostic and Statistical Manual's criteria for  
37 PTSD (APA, 2013). Traumatic exposure can also lead to clinical levels of anxiety,  
38 depression, burnout and secondary trauma, tools which measure these conditions  
39 also need to be part of any screening/surveillance programme. Dissociation is a  
40 common state following a traumatic exposure. Tools to measure post-trauma  
41 dissociation (DESI) and peritraumatic dissociation (PDEQ) are included in Table 1.  
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- 48 c) An assessment of associated personal and work-related factors is also included in a  
49 surveillance programme as these provide some indication of what makes some ERSs  
50 more vulnerable to becoming affected by traumatic events. This additional  
51 information is useful when designing interventions to be used to increase resilience  
52 and help to develop training and education programmes. Adverse childhood  
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3 experiences, personality, sense of purpose, coping styles and work engagement have  
4 all been found to be related to the magnitude of trauma symptoms.

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6 d) For the small number of ESRs that require trauma treatment it is important to have  
7 suitable diagnostic tools. The CAPS-5 is seen as the gold-standard tool for diagnosis  
8 but this can only be administered by a clinician qualified in administering and  
9 interpreting this scale. The PSS-I-5 can be used for a similar function. (A diagnosis  
10 of PTSD is necessary when seeking medical retirement). However, for trauma  
11 psychologists and therapists the use of formulation and psychological assessment  
12 are more appropriate tools as these lead to the development of post trauma  
13 interventions and support.  
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22 **Note:** Psychological screening and surveillance tests are protected, and the disclosure of  
23 test materials is prohibited, as the unauthorised access to psychometric test material erodes  
24 their validity and reliability. There is also a need for anyone involved in the administration or  
25 interpretation of screening results to be appropriately qualified. In addition, there are strict  
26 rules relating to the confidentiality of the results and the protection of this data from  
27 unauthorised access.  
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### 33 **Discussion**

34 It is recognised that there are increasing pressures being placed on emergency services to  
35 deal with the trauma of terrorism, natural and manmade disasters, interpersonal violence  
36 and personal tragedies. Alongside, there is a continual reduction in funding and an increase  
37 in workload, challenging the ability of the ESR to remain resilient and cope with the  
38 psychological burden. More frequently, internal support resources are stretched to their  
39 limits, with precious occupational health resources needing to be targeted effectively.  
40 There is a requirement for management and ESRs to become emotionally aware, and to  
41 have the knowledge and training in identifying the signs and symptoms of stress and trauma  
42 in themselves and their colleagues. If society is to be kept safe, emergency services must  
43 maintain their capability for dealing with emotionally challenging, complex and traumatic  
44 work, and introduce organisational systems and processes which meet the organisational,  
45 operational and personal needs of ESRs.  
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To be successful there is a need for the development of trauma informed organisational policies and procedures for dealing with disasters and other critical incidents, and for providing support to those affected (Bloom, 1997). Emergency services need to deliver trauma awareness training and education to supervisors and ESPs. This is critical when recognising and responding to signs and symptoms of traumatic stress, and is needed to provide evidence-based early interventions and regular screening and support to identify those who are struggling, as a means of reducing stigma and building wellbeing and trauma resilience (McFarlane & Bryant, 2007). This approach is being supported by Blue Light Framework (Hesketh & Williams, 2017), which aims to improve the psychological wellbeing of emergency service responders. Guidance on risk assessment and screening in emergency services which promotes a systematic approach to supporting ESRs (Hesketh et al, 2017) and on managing trauma in high risk organisations (Hesketh & Tehrani, 2018).

Psychological screening and surveillance of ESRs provides a simple and economic mechanism to identify ESRs in need of psychological support, and an opportunity to examine and quantify the impact of personal and organisational factors. These will, in turn, be influencing the level of trauma resilience with the aim of creating a workforce which is trained and equipped to recognise and build their psychological wellbeing; and for the emergency services to meet their duty of care by proactively promoting a trauma informed workforce.

## References

- ACPO (2007) *Combating Child Abuse on the Internet (CCAI): Practice Advice on the Protection of Workers Engaged in Identifying, Investigating, Tracking and Preventing on-line Child Sexual Abuse*, Association of Chief Police Officers
- APA (2013) *Diagnostic and Statistical Manual of Mental Disorders (fifth addition)*, Arlington, American Psychiatric Association
- Antanovski, A. (1996) The salutogenic model as a theory to guide health promotion, *Health Promotion International*, 11 (1) 11-18
- Arendt, M., Elklit, A., (2001) Effectiveness of psychological debriefing, *ACTA Psychiatrica, Scandinavia*, 104, 423-437
- Basoglu M. Salcioglu, E. :ovampi, M. Cyzeren, M. Aker, T. Kilic, C. Mestcioglu, O (2001) A study of the validity of a screening instrument for traumatic stress in earthquake survivors in Turkey, *Journal of Traumatic Stress*, 14 (3) 491-509

- 1  
2  
3 Bisson, J.L. McFarlane, A.C. Rose, S. (2000) Psychological Debriefing. In Foa E.B. Keane, T.M.  
4 Friedman, M.J. Eds. *Effective Treatments of PTSD*. New York, Guildford Publications 39-  
5 59  
6  
7 Bloom, S (1997) *Creating Sanctuary*, London, Routledge  
8 BPS (2018) *How can psychology inform disaster management*, Leicester, British  
9 Psychological Society.  
10  
11 Brewin, C. R., Rose, S. Andrews, B. Green, J. et al (2002) A brief screening instrument for  
12 post traumatic stress disorder. *British Journal of Psychiatry*, 181, 158-162  
13  
14 Brewin, C.R., Scagg, P. Robertson, M. Thompson, M. et al. (2008) Promoting mental health  
15 following the London bombings: a screen and treat approach, *Journal of Traumatic*  
16 *Stress*, 21 (1) 3-8  
17  
18 Cabinet Office (2012) Emergency Preparedness,  
19 <https://www.gov.uk/government/publications/emergency-preparedness> downloaded  
20 18.02.2018  
21  
22 Carleton, R.N., Afifi, T.O. Turner, S. Taillieu, T. Duranceau, S. LeBouthillier, D. Sareen, J. et.al  
23 (2018) Mental disorder symptoms among public safety personnel in Canada, *The*  
24 *Canadian Journal of Psychiatry*, 63(1) 54-64  
25  
26 Carlson, E.B. Putnam, F.W. (1993) An update on the dissociative experiences scale,  
27 *Dissociation*, 6, 16-26  
28  
29 Carver, C.S. Scheier, M.F. Weintraub, J.K. (1989) Assessing coping strategies: a theoretical  
30 based approach, *Journal of Personality and Social Psychology*, 56 267-283  
31  
32 Castro, C.A. Hoge, C.W. Cox, A.L. (2006) Battlemind training: building soldier resiliency. In  
33 *Human dimensions in Military Operations – Military Leaders’ strategies for addressing*  
34 *stress and psychological support*. pp42-1 – 42-6, Meeting proceedings Neuilly-sur-Seine,  
35  
36 Castro, C.A. (2014) The US framework for understanding, preventing and caring for the  
37 mental health needs of service members who served in combat in Afghanistan and Iraq:  
38 a brief review of the issues and the research; *The European Journal of*  
39 *Psychotraumatology*, 5 :24713 -<http://dx.doi.org/10.3402/ejpt.v5.24713>  
40  
41 College of Policing (2018) Responding to Trauma in Policing: a practical guide, Coventry,  
42 College of Policing. [https://oscarkilo.org.uk/responding-trauma-policing-new-college-](https://oscarkilo.org.uk/responding-trauma-policing-new-college-guidance/)  
43 [guidance/](https://oscarkilo.org.uk/responding-trauma-policing-new-college-guidance/) downloaded 18.02.2018  
44  
45 College of Policing (2016) *Psychological Risk Management: Introduction & Guidance*,  
46 Coventry, College of Policing Ltd.  
47 [https://oscarkilo.org.uk/wp-content/uploads/2017/05/Psychological-Risk-](https://oscarkilo.org.uk/wp-content/uploads/2017/05/Psychological-Risk-Management-v6.pdf)  
48 [Management-v6.pdf](https://oscarkilo.org.uk/wp-content/uploads/2017/05/Psychological-Risk-Management-v6.pdf) downloaded 18.02.2018  
49  
50 College of Policing (2015) Recruit Assessment Centers for Police Constables.  
51 [http://recruit.college.police.uk/Officer/after-i-apply/Pages/Constables-Assessment-](http://recruit.college.police.uk/Officer/after-i-apply/Pages/Constables-Assessment-Centre.aspx)  
52 [Centre.aspx](http://recruit.college.police.uk/Officer/after-i-apply/Pages/Constables-Assessment-Centre.aspx) downloaded 18.02.2018  
53  
54 College of Policing (2014) Job Related Fitness Tests. [http://www.college.police.uk/What-we-](http://www.college.police.uk/What-we-do/Standards/Fitness/Documents/PoliceFitnessGuidance.pdf)  
55 [do/Standards/Fitness/Documents/PoliceFitnessGuidance.pdf](http://www.college.police.uk/What-we-do/Standards/Fitness/Documents/PoliceFitnessGuidance.pdf) downloaded 18.02.2018  
56  
57  
58  
59  
60

- 1  
2  
3 Craun, S.W. Bourke, M.L. Bierie, D.M. Williams, K.S. (2014) A longitudinal examination of  
4 secondary traumatic stress among law enforcement, *Victims and Offenders*, 9, 299-316  
5  
6 Creamer, M.C. Varker, T. Bisson, J. Darte, K. Greenberg, N. Lau, W. Moreton, G. O'Donnell,  
7 M.  
8 Richardson, D. Ruzek, J. Watson, P. Forbes, D. (2012) Guidelines for Peer Support in High-  
9 Risk Organisations: an international consensus study using the Delphi Method, *Journal*  
10 *of Traumatic Stress*, 25, 134-141  
11  
12 Dantzker, M.L. (2011) Psychological pre-employment screening for police candidates  
13 seeking consistency if not standardisation, *Professional Psychology, Research and*  
14 *Practice*, 42, 3, 276-283  
15  
16 Dollard, M. Skinner, N. Tuckey, M Bailey, T. (2007) National surveillance of psychosocial risk  
17 factors in the workplace: An international overview *Work and Stress* 21(1):1-29  
18  
19 Dyregrov, A. (2002) *Psychological Debriefing: a leader's guide for small group crisis*  
20 *intervention*, Ellicott City, MD. Chevron Publishing  
21  
22 Ehlers & Clark (2000). A cognitive model of posttraumatic stress disorder. *Behaviour*  
23 *Research & Therapy*, 38(4), 319-345.  
24  
25 ESCWG (2016) *Emergency Services Collaboration Working Group National Overview*,  
26 <https://aace.org.uk/wp-content/uploads/2016/11/National-overview-v13-WEB.pdf>,  
27 downloaded 18.02.2018  
28  
29 European Agency for Safety and Health at Work (2011) *Emergency Services: a literature*  
30 *review on occupational safety and health risks*, Luxembourg, Publications office of the  
31 European Union.  
32  
33 Eysenck, SBG, Eysenck, HJ Barrett PA (1985) A revised version of the psychoticism scale,  
34 *Personality Individual Differences*, 6 (1) 21-29  
35  
36 Felitti MD, Anda RF, Nordenberg MD, et al. (1998) Relationship of childhood abuse and  
37 household dysfunction to many of the leading causes of death in adults: the Adverse  
38 Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*; 14: 245-  
39 258  
40  
41 Foa, E & Tolin, DF (2000). Comparison of the PTSD Symptom Scale-Interview Version and the  
42 Clinician-Administered PTSD Scale. *Journal of Traumatic Stress*, 13, 181-191  
43  
44 Goldberg, D, Bridges, K. Duncan-Jones, P.Grayson, D. (1988) Detecting anxiety and  
45 depression in general medical settings, *British Medical Journal*, 297, 897-899  
46  
47 Greenberg, N (2015) Psychological impact of traumatic events: guidance for trauma-  
48 exposed organisations, *Occupational Health at Work*, 12 (1) 17-21  
49  
50 Guardian (2016) Police Sick-leave for Psychological Reasons up by a Third in Five Years.  
51 05/04/2016 [https://www.theguardian.com/uk-news/2016/apr/05/police-sick-leave-for-](https://www.theguardian.com/uk-news/2016/apr/05/police-sick-leave-for-psychological-reasons-up-by-a-third-in-five-years)  
52 [psychological-reasons-up-by-a-third-in-five-years](https://www.theguardian.com/uk-news/2016/apr/05/police-sick-leave-for-psychological-reasons-up-by-a-third-in-five-years) downloaded 18.02.2018  
53  
54 HSE (1999) *Health Surveillance*, HSG61, Norwich, HSE Books  
55  
56 Halpern, J. Gurevich, M. Schwartz, B. Brazeau, P. (2009) What makes an incident critical for  
57 ambulance workers? Emotional outcomes and implications for intervention, *Work &*  
58 *Stress*, 23, (2) 173-189  
59  
60

- 1  
2  
3 Hesketh, I., Williams, S. (2017). 'Blue Light Wellbeing Framework.' College of Policing Ltd.  
4 Retrieved from: <https://oscarkilo.org.uk/wellbeing-framework/> downloaded 18.02.2018  
5
- 6 Hesketh, I., Tehrani, N., Harrison, J. (2017). Psychological Risk Management: Introduction &  
7 Guidance. College of Policing Ltd. Retrieved from: [https://oscarkilo.org.uk/wp-](https://oscarkilo.org.uk/wp-content/uploads/2017/08/FINAL-Psychological-risk-management.pdf)  
8 [content/uploads/2017/08/FINAL-Psychological-risk-management.pdf](https://oscarkilo.org.uk/wp-content/uploads/2017/08/FINAL-Psychological-risk-management.pdf) downloaded  
9 18.02.2018  
10
- 11 Hesketh, I., Cooper, C. (2017) Measuring the People Fleet: General Analysis, Interventions  
12 and Needs. Strategic HR Review. 16 (1) pp 17-23  
13
- 14 Hesketh, I., Cooper, C. (2017). Managing Health and Well-Being in the Public Sector: A Guide  
15 to Best Practice. Routledge Psychology Press.  
16
- 17 Hutton, W. 2011. Independent Public Service Pension Commission. London: HM Treasury.  
18 HM Government (2016) Enabling Closer Working Between the Emergency Services  
19 Summary of consultation responses and next steps,  
20 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/4953](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/495371/6.1722_HO_Enabling_Closer_Working_Between_the_Emergency_Services_Consult..pdf)  
21 [71/6.1722\\_HO\\_Enabling\\_Closer\\_Working\\_Between\\_the\\_Emergency\\_Services\\_Consult..](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/495371/6.1722_HO_Enabling_Closer_Working_Between_the_Emergency_Services_Consult..pdf)  
22 [.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/495371/6.1722_HO_Enabling_Closer_Working_Between_the_Emergency_Services_Consult..pdf) downloaded 18.02.18  
23
- 24 HMIC (2016) The state of policing; *The annual assessment of policing in England and Wales*  
25 *2015*, London, Her Majesties Inspectorate of Policing  
26 [https://www.justiceinspectrates.gov.uk/hmicfrs/publications/state-of-policing-the-](https://www.justiceinspectrates.gov.uk/hmicfrs/publications/state-of-policing-the-annual-assessment-of-policing-in-england-and-wales-2016/)  
27 [annual-assessment-of-policing-in-england-and-wales-2016/](https://www.justiceinspectrates.gov.uk/hmicfrs/publications/state-of-policing-the-annual-assessment-of-policing-in-england-and-wales-2016/) downloaded 18.02.2018  
28
- 29 Ilmarinen, J. (2007) The Work Ability Index (WAI), *Occupational Medicine*, 57 160  
30
- 31 IOSH (2016) Occupational health management in the workplace A guide to the key issues of  
32 occupational health provisions, Wigston, IOSH  
33
- 34 Jones, E. Hyams, K.C. Wessely, S. (2003) Screening for vulnerability to psychological  
35 disorders in the military: a historical survey, *Journal of Medical Screening*, 10 (1) 40-46  
36
- 37 McFarlane, A.S. Bryant, R.A. (2007) Post-traumatic stress disorder in occupational settings:  
38 anticipating and managing the risk, *Occupational Medicine*. 57, 404-410  
39
- 40 Management of Health and Safety Regulations (1999) Management of Health and Safety  
41 Regulations <http://www.legislation.gov.uk/uksi/1999/3242/body/made?view=plain>  
42 Accessed: 02.04.2018  
43
- 44 Marmar CR, Metzler TJ, Otte C (2004): The Peritraumatic Dissociative Experiences  
45 Questionnaire. *Assessing Psychological Trauma and PTSD: A Handbook for Practitioners*.  
46 Edited by: Wilson JP, Keane TM. New York, NY: Guilford Press, 144-167  
47
- 48 Milliken, C.S. Auchterlonie, J.L. Hoge, C.W. (2007) Longitudinal Assessment of mental health  
49 problems among active and reserve component soldiers returning from the Iraq war,  
50 *JAMA*. 2007;298(18):2141-2148. doi:10.1001/jama.298.18.2141  
51
- 52 Mitchell, M. Stevenson, K. (2000) *Managing post incident reactions in the police service*,  
53 Caerphilly, HSE  
54
- 55 Mouthaan, J. Suhbrabduj, M. Reitsma, J.B. Gersons, B. P. R. Oliff, M. (2014) Comparing  
56 Screening Instruments to Predict Posttraumatic Stress Disorder, *Plos* 1, 9, (5) 97183  
57
- 58 National Audit Office (2015a) *Financial Sustainability of Police Forces in England and Wales*.  
59  
60

- 1  
2  
3 [https://www.nao.org.uk/wp-content/uploads/2015/06/Financial-sustainability-of-police-](https://www.nao.org.uk/wp-content/uploads/2015/06/Financial-sustainability-of-police-forces.pdf)  
4 [forces.pdf](https://www.nao.org.uk/wp-content/uploads/2015/06/Financial-sustainability-of-police-forces.pdf) downloaded 18.02.2018  
5 National Audit Office (2015b) *Impact of funding reductions on fire and rescue services*,  
6 [https://www.nao.org.uk/report/impact-of-funding-reductions-on-fire-and-rescue-](https://www.nao.org.uk/report/impact-of-funding-reductions-on-fire-and-rescue-services/)  
7 [services/](https://www.nao.org.uk/report/impact-of-funding-reductions-on-fire-and-rescue-services/)  
8 downloaded 18.02.2018  
9  
10 National Audit Office (2017) NHS Ambulance Services, [https://www.nao.org.uk/wp-](https://www.nao.org.uk/wp-content/uploads/2017/01/NHS-Ambulance-Services.pdf)  
11 [content/uploads/2017/01/NHS-Ambulance-Services.pdf](https://www.nao.org.uk/wp-content/uploads/2017/01/NHS-Ambulance-Services.pdf) downloaded 18.02.2018  
12 National Health Executive (2015) Rate of Paramedics leaving ambulance service nearly  
13 doubles <http://www.nationalhealthexecutive.com/News> downloaded 17.02.2018  
14  
15 Otto, J.L. Holodniy, M. DeFraitcs, R.F. (2014) Public Health Practice is not research, *American*  
16 *Journal of Public Health*, 104 (4) 596-602  
17  
18 Price, M. Kuhn, E. Hoffman, J.E. Ruzek, J. Acierno, R. (2015) Comparison of the PTSD  
19 checklist (PCL) administered by mobile device relative to paper form. *Journal of*  
20 *Traumatic Stress*, 28 (5) 480-483  
21  
22 Regel, S. Dyregrov, A. (2012) Commonalities and New Directions in Post-trauma Support  
23 Interventions: from Pathology to the Promotion of Post-traumatic Growth, In R.Hughes,  
24 A. Kinder & C.Cooper, Eds. *International Handbook of Workplace Trauma Support*,  
25 Chichester, Wiley-Blackwell  
26  
27 Rona, R. Hooper, R. Jones, M. Hull, L. Browne, T. Horn, O. Murphy, D. Hotopf, M. Wessely, S.  
28 (2006) Mental health screening in armed forces before the Iraq war and prevention of  
29 subsequent psychological morbidity: follow up study *British Medical Journal* 333:991  
30  
31 Ruck, S. Bowes, N. Tehrani, N. (2013) Evaluating trauma debriefing within the UK prison  
32 service, *The Journal of Forensic Practice*, 15 (4).281-290  
33  
34 Shakespeare-Finch, J. (2011) Primary and secondary trauma in emergency personnel.  
35 *Traumatology*, Vol 17(4)  
36  
37 Schaufeli, W.B. Bakker A.B. (2006) The measurement of work engagement with a short  
38 questionnaire, *Educational and Psychological Measurement*, 66 (4) 701-716  
39  
40 Sijrandij, M. Oliff, M. Opmeer, B.C. Carkuer, I.V.E. Gersons, B.P.R. (2008) Early prognostic  
41 screening for posttraumatic stress disorder with the Davidson Trauma Scale and the  
42 SPAN. *Depression & Anxiety*, 25 1038-1045  
43  
44 Simcock, T. (2015) Evidencing organisational change in the UK Fire and Rescue Services, *Fire*  
45 *Protection*, Oct 44-45  
46  
47 Skogstad, M. Slorstad, M. Lie, A. Conradi, H.S. Heir, T. Weisaeth, L. (2013) Work-related  
48 post-traumatic stress disorder. *Occupational Medicine*, 2013; 63:175-182  
49  
50 Slottje, P. Witteveen, A.B. Twisk, J.W.R., Smidt, N. Huizink, A.C. Mechelen, W. Smid, T.  
51 (2008) Post disaster physical symptoms of firefighters and police officers: Role of types  
52 of exposure and post-traumatic stress symptoms. *British Journal of Health Psychology*,  
53 13, 327-342  
54  
55 Spitzer RL, Kroenke K, Williams JB, et al;(2006) A brief measure for assessing generalized  
56 anxiety disorder: the GAD-7. *Arch Intern Med*. 22;166  
57  
58  
59  
60



- 1  
2  
3 Stamm, B.H. (2010) *The concise ProQOL manual*, Pocatello, ID, ProQOL.org.
- 4 Tehrani, N. Cox, T. Cox S. (2002) Assessing the Impact of stressful events in organisations:  
5 the development of an extended impact of events scale, *Counselling Psychology*  
6 *Quarterly* 15, 2, 191-200
- 7  
8 Tehrani, N. MacIntyre, B. Maddock, S. Shaw, R. Illingworth, R. (2007) Rehabilitation:  
9 Maintaining a healthy workforce. In Scott McIntye & Jonathan Houdmont (eds) *Health*  
10 *Psychology- European perspectives on research, education and practice*. SerSilito –  
11 Maia, ISMAI
- 12  
13 Tehrani, N. (2014) Trauma, Resilience and Growth, *Occupational Health and Wellbeing*, April  
14 <https://www.personneltoday.com/hr/trauma-resilience-growth/> downloaded  
15 18.02.2018
- 16  
17 Tehrani, N. (2016) *Counselling Psychology for Trauma in Emergency Service Occupations* In  
18 David Murphy Ed. *Counselling Psychology: a textbook for study and practice*,  
19 Chichester, Wiley
- 20  
21 Tehrani, N. (2016a) Extraversion, neuroticism and secondary trauma in Internet child  
22 abuse investigators, *Occupational Medicine*, 66 (5) 403-407
- 23  
24 Tehrani, N. (2018) Child Protection: long-term implications on psychological wellbeing and  
25 workability. *Occupational Medicine*, kqy016 doi:10.1093/occmed
- 26  
27 Tuckey, M., & Scott, J. E. (2014). Group critical incident stress debriefing with emergency  
28 services personnel: A randomized control trial. *Anxiety, Stress and Coping*, 27(1), 38–54
- 29  
30 Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2014).  
31 PTSD Checklist for DSM-5 (PCL-5). National Center for PTSD.  
32 <http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>
- 33  
34 Weiss, D.S. Bruner, A. Best, S.R. Metzler, T.J. Liberman, A. Pole, N. Fagan, J.A. Marmar, C.R.  
35 (2010) Frequency and severity approaches to indexing exposure to trauma: the critical  
36 incident history questionnaire for police officers, *Journal of Traumatic Stress*, 23 (6)  
37 734-743
- 38  
39 Weiss, D.S., Marmar, C.R. (1997) The impact of events scale-revised, In Wilson J.P. Keane,  
40 T.M. eds. *Assessing psychological trauma and PTSD*, New York, Guildford Press, pp399-  
41 411
- 42  
43 Winsor T. (2012) *Independent Review of Police Officer and Staff Remuneration*.  
44 [http://webarchive.nationalarchives.gov.uk/20130312170837/http://review.police.uk/p](http://webarchive.nationalarchives.gov.uk/20130312170837/http://review.police.uk/publications/part-2-report/)  
45 [ublications/part-2-report/](http://webarchive.nationalarchives.gov.uk/20130312170837/http://review.police.uk/publications/part-2-report/) downloaded 18.02.2018
- 46  
47 Wortley, R., Smallbone, S, Powell, M. Cassematis, P. (2014) *Understanding and managing*  
48 *the occupational health impacts on investigators of internet child abuse*, Brisbane,  
49 Griffith University; 2014
- 50  
51 Wright, K.M., Bliese, P.D., Thomas, J.L., Adler, A.B. Eckford, R.D. Hoge, C.W. (2007)  
52 Contrasting approaches to psychological screening with U.S. combat soldiers, *Journal of*  
53 *Traumatic Stress*, 20 (6) 965-975
- 54  
55  
56  
57  
58  
59  
60

Table 1: Examples of some screening and surveillance tools available for assessing post trauma responses

<b>Post Critical Incident Screening Tools</b>	<b>Developer</b>	<b>Features</b>	<b>Cut-off score</b>
Traumatic Stress Symptom Checklist (TSSC)	Basoglu et al. 2001	23 items 17 trauma items and 6 depression items. Four- point scale	25 or higher
The Impact of Events Scale-Revised (IESE-R)	Weiss & Marmar, 1997	22 items which measure intrusion, avoidance and hyperarousal. Five-point scale.	Varied
The Trauma Screening Questionnaire (TSQ)	Brewin et al., 2002	10 items. Five intrusion items and five hyperarousal items. Yes/No scale	6 or higher
The Davidson Trauma Scale (DTS)	Sijbrandij et al 2008	17 items rated for frequency and severity during the previous week. Five-point scale	20 or higher
SPAN (short form of DTS)	Sijbrandij et al 2008	4 items Startle, Physiological Arousal, Anger and Numbness. Five-point scale	5 or higher
<b>Clinical Assessment Tools</b>	<b>Developer</b>	<b>Features</b>	<b>Cut-off score</b>
PTSD Checklist 5 (PCL-5)	Weathers et al, 2014	20 items 5 re-experience, 2 avoidance, 7 neg. self-belief, 6 arousal five-point scale	33 or higher
PTSD Symptom Scale (PSS-5)	Foa & Tolin, 2000	20 items 5 re-experience, 2 avoidance, 7 neg. self-belief, 6 arousal five-point scale	33 or higher
Impact of Events Scale – Extended (IES-E)	Tehrani et al, 2002	23 items which measure intrusion, avoidance and hyperarousal. Five-point scale.	50 or higher
General Anxiety Disorder-7 (GAD-7)	Spitzer et al, 2006	7 items which measure anxiety. Four-point scale	10 or higher
Goldberg Anxiety/Depression Scale	Goldberg et al. 1988	9 items anxiety items and 9 depression items Yes/No scale	5 or more both items
Peritraumatic Dissociative Experiences (PDEQ)	Marmar et al 2004	10 items Five-point scale	12 or higher
Dissociative Experiences Scale II (DESI)	Carlson & Putnam 1993	28 items scored on % of time symptom experienced	30% or higher
Professional Quality of Life-Revised (ProQOL R)	Stamm, 2010	30 items 10 compassion satisfaction (CS), 10 burnout (BO), 10 compassion fatigue (CF) six- point scale	CS 30 or lower, BO 31 or higher, CF 15 or higher
<b>Resilience Assessment Tools</b>		<b>Features</b>	
Adverse Childhood Experiences (ACE)	Felitti et al 1998	5 items measure adverse childhood experiences and 5 items measure childhood adversity Yes/No scale (Score of 4 or more are significant)	
Sense of Coherence (SoC)	Antovsky, 1996	13 items 4: meaningfulness, 5 comprehensibility, 4 manageability. Seven-point scale	
Eysenck Personality Questionnaire-Revised (EPQ-R)	Eysenck et al. 1985	60 items 5 subscales, extraversion/introversion, sensitivity (neuroticism), tough-mindedness (psychoticism), social desirability and impulsivity.	
Cope Inventory	Carver et al, 1989	13 coping subscales some are active and others passive. This measure is useful when taken together with data from other measures where it can identify coping styles and tendencies.	
Utrecht Work Engagement (UWE)	Schaufeli & Bakker 2003	3 engagement scales, vigour, dedication, and absorption. The UWE has shown that some people can be engaged in their work and become burnt out due to being over conscientious or driven to succeed.	
Work Ability Score (WAS)	Ilmarinen, 2007	A single item measures work ability. It has been taken from the Work Ability Index and has similar predictive qualities for physical and psychological wellbeing.	
<b>Diagnosis/Formulation Tools</b>	<b>Developer</b>	<b>Features</b>	
Clinician Administered PTSD Scale-5 (CAPS-5)	Weathers et al 2014	CAPS-5 is a 30-item structured interview (Gold Standard for trauma diagnosis)	
PTSD Symptom Scale (PSS-I-5)	Foa & Tolin, 2000	PSS-I-5 is the 20-item structured interview version of the PSS-5 using the same questions	
PTSD Formulation	Ehlers & Clark, 2000	Formulation based on cognitive model of trauma by Ehlers & Clark	
Psychological Assessment of PTSD	Tehrani et al, 2007	Structured interview and assessment process which builds on access to a comprehensive psychological screening	