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Early Intervention Following Trauma: a controlled longitudinal study at Royal Mail Group

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ies
Report 435

Published by:

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Mantell Building
University of Sussex Campus
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Brighton BN1 9RF
UK

Tel. + 44 (0) 1273 686751
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http://www.employment-studies.co.uk

British Library Cataloguing-in-Publication Data

A catalogue record for this publication is available from the British Library

ISBN 1 85184 366 3

Printed in Great Britain

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RMG

Royal Mail has been pleased to support and work with the partners undertaking this research, which has taken many years to develop and complete, we care about people who are unfortunate enough to experience traumatic events, and hope that this work will help inform their treatment and support in the future. We are one of the largest employers in the UK, employing just under 200,000 staff in a wide range of occupations and situations. Consisting of three main operational businesses, Post Office Ltd has 14,300 retail outlets, Parcel Force Worldwide is a well known parcels courier and Royal Mail Letters collects and delivers letters serving 28 million address throughout the country.

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BOHRF is a niche charity that identifies the need for evidence based research to answer practical questions in occupational health and related performance and HR issues. BOHRF brings together employers in both private and public sector with competent researchers to manage the research and to disseminate the outcomes that have direct practical application at work and are of global relevance. BOHRF is advised by the independent FOM Research Committee and by peer reviewers to ensure that research that is funded is based on robust methodology. BOHRF will only fund research that has direct practical application at work.

Acknowledgements

Many people were involved in this research over the years. In particular we wish to thank Dr Steve Boorman (RMG) who has championed the research from the start and ensured the continuity of the project through periods of major organisational change at RMG.

Dr Steve Deacon (RMG) has provided generously of his time and support and latterly has played a critical role in facilitating access to centrally held records at RMG and ensuring a complete data set for the evaluation. Dr Su Wang (RMG) has been very supportive of this project and played an important role during the middle of the project.

Brian Glover and Norma Spence at RMG have both done sterling work in collating data for the project and we are grateful for their efforts on our behalf.

At BOHRF, Brian Kazer and Dr David Murray Bruce have been unstinting in their support for the project, Brian also managed the Steering Group, an invaluable source of guidance and advice. Members of the Steering Group were: John Aitken, Sharon Allaway (Rail Standards and Safety Board), Gaynor Anderson (Rail Standards and Safety Board), June Chandler (UNISON), Toyin Davies (Rail Standards and Safety Board), Steve Deacon (Royal Mail Group), Richard Jones (Institution of Occupational Safety and Health), Laura McDonnell (Health and Safety Executive), David Murray Bruce (Trustee of BOHRF), Mary Newsome (NHS Employers), Jon Richards (UNISON) and Luise Vassie (Institution of Occupational Safety and Health), Su Wang (Royal Mail Group). We thank them for their inputs.

We are also very grateful for the ongoing support from RMG unions, including the Post Office Federation) during the whole of the research. Their involvement has been an important part of the success of this research – in particular our thanks go to Dave Joyce from the CWU and Phil Purnell from the CMA.

At IWP Dr Chris Stride conducted the majority of the statistical analyses in the report and both Malcolm Patterson and Professor Mark Griffin have advised on further analyses.

At IES, Sally Wilson has helped with the preparation of the final report, particularly Chapters 3 and 4 and Claire Tyers helped in the final stages of report preparation and amendments. Alice Sinclair and Rob Barkworth were both involved in the data collection stages, conducting interviews with respondents and managing the research process at various stages.

Bekki Kendrick at IWP, Denise Hassany and Louise Paul at IES have together produced the final document.

The organisations that contributed project funding to enable this research to be funded need particular thanks. They include NHS Employers, RSSB, Health and Safety Executive and Fire Brigades Union.

Above all we wish to acknowledge the Royal Mail Group employees and Post Office franchise holders who took the time to complete questionnaires and participate in interviews.

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Executive Summary

Introduction

This research was commissioned by the British Occupational Health Research Foundation (BOHRF) to investigate safe and effective trauma management procedures, including the provision of support, for organisations whose employees experience serious incidents at work.

The Royal Mail Group (RMG) approach to trauma management is a relatively simple, yet structured process. It can be implemented in many different work settings and offers varying levels of support to employees as appropriate. If effective, an approach such as this can be the basis for other organisations to develop effective trauma management practices.

Over a two-year period, 815 RMG workers were identified as having been exposed to a potentially traumatic incident and then tracked for a 13 month period. The findings from this research contribute to knowledge of trauma management in three important ways. Robust, longitudinal evidence from an organisational perspective provides evidence that:

- the trauma management procedures used at RMG are a safe response to trauma
- the 'support post trauma' (SPoT) protocol is effective in relaying information to employees about symptoms and further sources of support within the organisation
- organisational activity which enhances an individual's feeling of support post-trauma (particularly practical support) is associated with lower symptoms at three months and lower absence at 12 months.

The implications of these findings in relation to the National Institute for Health and Clinical Excellence (NICE) guidelines on the treatment of psychological trauma and organisational approaches to trauma management are considered below and in the report.

Managing workplace trauma

Many people spontaneously recover from traumatic incidents. However, population estimates suggest that a significant group (typically around 25 per cent) will not recover on their own and could benefit from some kind of support. There are no specific figures for recovery from traumatic incidents at work.

Employers are increasingly concerned about the impact of traumatic incidents on employees. The fact that employers have a responsibility for the protection of employees' psychological health is well-established and enshrined in law. However, evidence for good practice on how to manage traumatic incidents in the workplace is less clear, leaving many employers with little or no guidance on what to do for the best. The advice in current National Institute for Health and Clinical Evidence (NICE) guidelines for care settings, while clear, is more difficult to apply in other organisational settings.

This gap in the evidence about what works best in an organisational setting means that much organisational activity in response to traumatic events is based on anecdotal evidence or professional consensus rather than proven safety or effectiveness.

Historical support within organisations

One approach which gained widespread favour within organisations is that of 'psychological debriefing' or 'critical incident stress debriefing'. The lack of evidence about best organisational practices for managing trauma has led in some instances to prolonged use of these approaches. This is in spite of evidence from other sources (ie clinical research) on psychological debriefing/critical incident stress debriefing which shows that at best the effects are neutral and at worst there can be negative outcomes for some individuals – NICE now recommends **against** the use of one-off debriefing.

Recommended support post-trauma

The recommended approach in health settings post trauma is 'watchful waiting' as set out by the NICE guidelines. In a medical context, watchful waiting describes a process of closely monitoring a patient without active treatment of the problem in situations where there is a high expectation of self resolution or the risks of a therapy potentially outweigh its benefits. Watchful waiting is considered a reasonable response post-trauma where it is not known whether active treatment will help and evidence suggests that most people will spontaneously recover. It is also clear how such an approach in an acute hospital setting could be incorporated into a wider care plan. By contrast, watchful waiting in other (ie non-health) organisational contexts can be impractical or difficult to deliver as it requires individuals with the expertise to identify problems available to closely monitor those who have been exposed to a trauma. The NICE guidelines also recognize the importance of various forms of support. Within a work

setting, organisational strategies for delivering practical, social and emotional support are far easier to envisage.

The current research

Research to date has been dominated by studies of the effects of debriefing on symptom levels. The current research aims to provide evidence about the effects of specific interventions which do not involve intense re-exposure. The research is conducted in organisational settings with a wider focus than the evaluation of symptom levels alone. We propose that a framework is needed for the provision of support to meet individual and organisational needs post trauma. This research aims to describe that framework by presenting evidence on what organisations can do for employees that is safe and effective.

Royal Mail Group

RMG is the largest employer in the UK outside the NHS, with virtually all job types occurring within the organisation. Exposure to trauma arises both through the types of incident that occur in many jobs eg, a fall or a road traffic accident and through incidents more specific to the nature of the job (ie cash handling).

The RMG trauma management programme was introduced over ten years ago and has evolved to its present-day format, which constitutes three phrases:

- practical support on the day of the incident in the form of crisis management
- a SPoT protocol, designed to ensure managers provide appropriate practical, emotional and social support
- further ongoing support from the professional trauma counselling service.

Organisational changes and staff moves within RMG between 1995 and 2000 meant that the trauma management programme had lapsed in parts of the organisation. Before the start of this research RMG rolled out a new manager training programme to selected managers to ensure that appropriate social, practical and emotional support was offered to employees. This became known as the SPoT protocol.

Research design

A robust research design was adopted, where all employees exposed to a range of pre-determined incident types were included in the study and tracked for 13 months. Types of incidents were wide ranging and included robberies, attempted robberies, armed robberies, hostage taking situations, dog attacks, physical assaults, accidents, falls and road traffic accidents.

Participants were recruited to the study between August 2002 and September 2004. The final 13-month follow-up questionnaires were sent out in October 2005 and the survey closed in January 2006.

Data were gathered from a range of different sources:

- Questionnaires were sent at three time points: immediately post incident, at three months and at 13 months.
- Objective data on incident type, absence, contract status and further support were collected direct from the organisation for all relevant employees identified as experiencing an incident.

The final research sample included employees from three main areas: cash handling and delivery, Post Office networks and service delivery.

Sample description

Overall, 55 per cent of the potential sample responded at one or more time points in the survey and drop-out was relatively low during the course of the follow-up. At wave one the response rate was 48 per cent, at wave two 32 per cent and at wave three 22 per cent. The achieved sample is felt to be a good representation of all possible respondents and no significant differences between respondents and non-respondents, such as absence or contract status, were identified.

There were some differences in response rates with regard to businesses area and type of incident. The most commonly reported features of incidents were counter snatch or raid, weapons, dog attacks and physical assaults. However, all three business areas and a wide range of incidents were represented in the survey respondents.

The vast majority of respondents had directly experienced the incident rather than witnessed it and two-thirds were working remotely when they experienced the incident.

The impact of post-trauma support

Thirty-seven per cent of respondents reported receiving some form of crisis management on the day of the incident and almost one-third of respondents participated in a SPoT meeting.

Employees attending SPoT meetings reported significantly higher scores than non-attendees on three important aspects of post trauma management:

- **reassurance** that the symptoms they might be experiencing were normal
- knowledge about sources of **further information** about traumatic reactions
- knowledge about where in the organisation to access **further support**.

Those who attended SPoT meetings were also far more positive in their views of RMG and the role of support in enabling them to get back to normal, in some cases this extended to more confidence about returning to work.

Symptom levels in this group were measured post incident, at three months and at 13 months. As would be expected because of natural recovery, significant drops in symptom level were found at both three and 13 months. There was some variation in symptom level by business area and type of incident. Over time, these differences became less marked.

There were no differences in symptom levels between those offered a SPoT meeting or not at 13 month follow-up, although some differences were found immediately post incident with lower symptoms among those who had already attended a SPoT meeting. No significant differences were found among those offered the intervention at the three month follow-up. This indicates that the SPoT intervention is safe to use in organisational settings. Its use is not associated with increased symptoms and the process was found to have positive organisational benefits.

Support and absence

Absence was found to be significantly correlated with perceived organisational support, with those who felt supported immediately post trauma also having lower absence 12 months later.

The patterns of symptoms and absence in relation to the level of perceived support hinted at much more complex relationships within the data. Various models were tested to explore these relationships. A complex model, based on RMG procedures, was tested using the structural equation modelling (SEM) statistical package LISREL. As predicted, higher levels of perceived organisational support immediately post trauma were found to be linked both to lower symptom levels at three months and to lower absence levels at 12 months.

Perceived organisational support

Perceived organisational support became a critical variable in the analyses. These findings suggest that the way an individual perceives the organisational support they receive is more important than any specific intervention. Both support on the day of the incident and attendance at a SPoT meeting were important constituents of perceived organisational support post trauma. A higher level of perceived organisational support immediately post trauma was shown to be linked to lower symptom levels at the three month follow up, which in turn were related to lower absence at 12 months.

'Good' support – ie the factors immediately post trauma that were associated with reduced symptom levels – was found to be an empathic response from the line manager and prompt practical support in dealing with the situation, and getting back to normal.

In relation to the SPoT meetings, the most important aspects of 'good' support were found to be in relation to the educational aspects of meeting ie information about where to go to obtain further support within the organisation, identification of symptoms individuals might have been experiencing since the incident and information about the normal reactions to trauma and coping-mechanisms.

Conclusions

These results highlight the importance of the organisation's response to trauma. They indicate that the way an organisation responds when employees experience trauma at work can have an impact on subsequent symptom levels and absence.

The trauma management procedures developed by RMG (ie crisis management and SPoT meetings) are safe and effective mechanisms for delivering practical, social and emotional support post trauma. Neither approach is independently linked to symptoms and absence, but both are linked via perceived organisational support to reduced symptoms and reduced absence.

The advantage of the RMG approach is that it is a relatively simple yet structured approach which can be implemented in many different work settings. An approach such as this can be the basis for an organisation to develop effective trauma management practices.

Future research

This study has identified that the way individual employees perceive the support offered by their organisation post trauma could play an important part in their recovery. Some evidence is available from this research about the factors influencing perceived organisational support. Further research to understand these factors better will help organisations to hone their trauma management practices in the future.

1 Background and Introduction

1.1 Background to the current research

In recent years there has been increasing awareness among employers of the need to protect the psychological as well as the physical health of employees. Published estimates of the national cost of psychological-ill health among workers (HSE, 2003) as well as clarification of employers' legal responsibilities in this area have put employee psychosocial health at the top of the management agenda.

At the same time that these general changes have been taking place, understanding has been growing of the extent to which certain severe stressors can impact on an individual's ability to function effectively, in both their personal and their professional lives. Understanding has developed in relation to the pattern of harm that follows traumatic events and the range of situations or experiences that can give rise to such reactions.

Significant for many employers is the recognition that traumatic symptoms can be experienced as a result of exposure, not only to extreme events such as war, acts of terror or natural disaster, but also to more commonly experienced events which occur in the course of a working day (eg a road traffic accident). In some instances, events such as physical or verbal assault, armed raids or even hostage taking situations occur precisely because of the nature of the work being undertaken (eg handling cash or valuables, dealing with the public, providing or withholding a service).

The specific pattern of symptoms that can follow exposure to a traumatic event and the diagnostic criteria for post traumatic stress disorder (PTSD) and adjustment disorder (AD) are now relatively well researched and documented. In recent years, attention has focused on developing responses that serve to minimise further psychological harm post trauma.

The British Occupational Health Research Foundation (BOHRF) commissioned this research in response to a recognised need among organisations for evidence-based advice on how to manage workplace trauma best.

This chapter covers:

- the research context including: definitions of PTSD; the diagnostic criteria; the normal course of post-trauma reactions; and the proportions of people likely to develop PTSD following exposure to traumatic incidents (Section 1.2)
- a summary of the implications of PTSD for organisations (Section 1.3)
- organisational approaches to trauma management (Section 1.4), including a description of psychological debriefing, a summary of the evidence on debriefing, a discussion of what else is recommended (Section 1.5)
- the aims and objectives of the current research (Section 1.6).

1.2 Research context

This section summarises current thinking on definitions of PTSD, typical reactions to traumatic experiences and current prevalence.

1.2.1 Definitions of PTSD

It has been suggested (Wilson, 1995) that the category of gross stress reaction, which appeared in the original edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952 is the first modern instance of recognition and understanding of something akin to PTSD. This 1952 DSM entry refers to individuals who are 'under conditions of great or unusual stress' and to the fact that the diagnosis was only justified when the individual was exposed to 'severe physical demands or extreme emotional stress such as in combat or in civilian catastrophe'.

PTSD first appeared in the late 1970s as a classifiable psychiatric syndrome (APA, 1979). This recognition was in part owing to the large numbers of Vietnam veterans who were suffering from a 'post-Vietnam' syndrome, exhibiting varying combinations of 'anxiety and hyperarousal, depression and guilt, impulsive or violent behaviour, social alienation, or isolation and often substance abuse' (US Army, 1994). However, this clustering of symptoms was also being recognised in non-military situations, such as victims of disasters and violent crimes.

Since its first appearance in 1979, the definition of PTSD has undergone a number of refinements. One significant change is the removal of the qualifier that the type of events giving rise to PTSD should be 'outside the range of normal human experience'. Instead, emphasis is placed on the way the individual responds to a situation (that they experience hopelessness or helplessness) and the experiencing of three distinct clusters of symptoms for a period of time after exposure to the incident. In other words

the definition and the diagnostic criteria now allow for the fact that a far wider range of situations than previously thought can give rise to trauma symptoms.

Importantly for organisations, such situations are ones which might be encountered by a wide range of employees in the course of their work (eg experiencing or witnessing road traffic accidents (RTAs), verbal or physical assault, armed raids or hostage taking situations).

1.2.2 Diagnostic criteria for PTSD

The accepted criteria for diagnosing a case of PTSD are found in the Diagnostic and Statistical Manual for Mental Health 4th edition (DSM-IV). Yehuda (2003) summarises the main clinical feature of PTSD as follows:

> *'Post traumatic stress disorder defines a rather specific syndrome in which trauma survivors are unable to get the traumatic event out of their minds. Three symptom clusters are associated with PTSD: 1) re-experiencing symptoms refers to distressing images, unwanted memories, nightmares or flashbacks of the event that cause distress and attendant physical symptoms such as palpitations, shortness of breath and other panic symptoms; 2) the avoidance of reminders of the event, including people, places or things associated with the trauma and becoming emotionally numb, constricted or generally unresponsive to the environment; and 3) hyperarousal, which is reflected in physiological symptoms such as insomnia, irritability, impaired concentration, hypervigilance and increased startle responses. To meet DSM criteria for PTSD, symptoms in each of the three domains must not only be present, but also must be severe enough to cause substantial impairment in social, occupational or interpersonal domains. Furthermore, symptoms must be present for at least one month.'*

It is clear from this that the diagnostic threshold for PTSD reflects a state of severe disequilibrium. Although the label PTSD is usually the one people are aware of, many individuals may well experience some symptoms without meeting the DSM-IV criteria for a diagnosis of PTSD. However, such symptoms could still have a profound effect on an individual's ability to function (professionally) on a day to day basis. This is defined in DSM-IV as 'adjustment disorder' (AD).

1.2.3 The normal course of post-trauma reactions

DSM-IV describes three stages in the course of post trauma reactions. The first stage immediately following the traumatic experience is defined as the first two days after the incident when:

> *'Some symptomology following exposure to an extreme stress is ubiquitous and does not require any diagnosis.'*
>
> DSM-IV, p 431

In the few weeks that follow exposure to a traumatic incident, DSM-IV notes that some people will continue to experience high levels of symptoms:

'Acute stress disorder should only be considered if the symptoms last at least two days and cause clinically significant stress or impairment in social, occupational, or other important areas of functioning or impair the individual's ability to do to pursue some necessary task …'

Essentially the symptomology of acute stress disorder (ASD) closely mirrors that of PTSD, except for the duration of the disorder. If ASD symptoms persist for longer than four weeks, a diagnosis of PTSD becomes appropriate or a diagnosis of adjustment disorder (AD) if symptoms are less severe.

In other words, many people are likely to suffer from some traumatic symptoms such as flashbacks to the event or 'hypervigilance' following exposure to a traumatic incident. This is considered a normal reaction in the short term (ie first few days) and needs no diagnosis. In most people such symptoms will diminish over the next few weeks. PTSD or AD is only considered as a diagnosis if symptoms persist for over four weeks.

The normal course of post trauma symptoms has important implications for measuring the effect of post trauma interventions. Most people experiencing a trauma will have high symptoms in the immediate aftermath; however, the majority will recover in subsequent weeks regardless of whether there is an intervention.

1.2.4 The scale of the problem in the community

Figures on the prevalence of PTSD in the UK civilian population are extremely hard to find. Where estimates of prevalence in other populations exist, the figures vary as the following statistics from North American populations demonstrate:

- Resnick et al. (1993) reported 12.3 per cent lifetime prevalence for PTSD in a national sample of women (USA).
- Kessler et al. (1995) report 7.8 per cent lifetime prevalence in the national co-morbidity survey (USA).
- Breslau et al. (1991) report 9.2 per cent lifetime prevalence in an urban population of young adults in the USA.

Overall Yehuda's (2002) conclusion, that PTSD affects between seven per cent and 14 per cent of the population at some point in their lives (lifetime prevalence), seems reasonable. Yehuda also reports that PTSD is the fourth most common DSM-III-R disorder.

When considering current prevalence (or the number of people affected at any given time) there is also considerable variation in estimates. Cuffe et al. (1998) report current prevalence of three per cent among women and one per cent among men in a community sample of older adolescents (USA). Resnick (op cit) reports 4.6 per cent prevalence within the past six months (USA national sample of women). Murray (1997) found that current prevalence of PTSD was 2.7 per cent for women and 1.2 per

cent for men in a Midwestern Canadian city. Creamer et al. (2001), reporting on the Australian National Survey of Mental Health and Well-being, found 12 month prevalence to be 1.3 per cent with women, who were more at risk than men of experiencing symptoms post trauma. The authors note that this prevalence rate is far lower than for comparable North American samples, yet still conclude that it is a highly prevalent disorder in the Australian community.

1.2.5 Proportions developing PTSD following exposure to trauma

As noted previously, only a proportion of those exposed to trauma will go on to develop PTSD or AD. Kessler (1995) concludes that about nine per cent of men and 20 per cent of women develop PTSD following a traumatic experience. Vassiliki et al. (2001) studied 434 consecutive admissions to accident and emergency clinics following RTAs. They found that 23 per cent met the criteria for PTSD four to six months after the accident. A review by Litz et al. (2002) concluded that although lifetime risk for exposure to potentially traumatizing events is high (60-90 per cent) prevalence of PTSD is low (around nine per cent).

Previous researchers have found that the nature of the trauma has a significant effect in determining the level of trauma experienced (Kessler et al, 1995; Rick et al, 1998; Yehuda, 2002). Kessler suggests that events involving interpersonal violence or events of human making (ie torture, rape, combat, and terrorism) can lead to prevalence rates of 50-75 per cent, whereas other events such as natural disasters or RTAs typically result in cases of PTSD in less than ten per cent of those exposed.

Yehuda commenting on Kessler makes the general point that:

> *'… for any given trauma, only a subset of people exposed will subsequently develop PTSD. These statistics suggest that viewing trauma survivors as a homogenous group and trying to base conclusions that might apply generally to such people may result in imprecise conclusions.'*

1.3 PTSD and the implications for organisations

This section discusses the implications for organisations. The next section describes organisational interventions.

The state of knowledge about reactions to trauma and the evidence base about trauma management practices pose several challenges for organisations:

- A wide range of situations can give rise to trauma symptoms. These include situations which certain types of employees are likely to experience, and all employees could experience, at some stage in their working life. Organisations therefore need to understand the situations that give rise to trauma and who in their organisation is at risk.

- Not all of those who are exposed to a traumatic situation will experience trauma symptoms. Dependant on the type of incident, research findings suggest that the majority will make a full recovery on their own; however, a significant minority (around 20-25 per cent) are likely to suffer from symptoms to a greater (PTSD) or lesser (AD) extent and to benefit from support. For organisations, that means while the majority of employees are likely to recover unaided, there are those who might still be experiencing significant interruption to normal daily functioning.
- Employees with the most extreme forms of reaction to a traumatic incident (PTSD) are more likely to be absent from work and more easily identifiable as being in need of appropriate treatment or support. However, this leaves the challenge for organisations of how they identify and provide appropriate support to those who may not be absent from work or meet the criteria for a diagnosis of PTSD but still experience some trauma-related symptoms, which may include those suffering from AD.

1.4 Organisational approaches to trauma management

Organisational approaches to the management of traumatic experiences at work tend to fall into three categories:

- pre-incident activities
- procedures during an incident
- post incident responses and support.

Previous research (Rick et al., 1998) identified a wide range of organisational activities in each of these categories (see Table 1.1). Much of this activity is not based on research evidence, but rather on anecdotal evidence or organisational consensus about what forms the best approach in a given setting. Use of these approaches varied by organisational setting; however, the most common post-incident activity among the case study organisations in the study was the use of psychological debriefing or critical incident stress debriefing (Rick et al., 1998). The appeal of debriefing in an organisational setting has been noted elsewhere in the literature (Raphael, 1995).

1.4.1 Psychological debriefing or critical incident stress debriefing

Although there are a number of different organisational approaches to preparing for, or dealing with trauma, it was psychological debriefing or critical incident stress debriefing which gained rapid acceptance and application within organisations.

Table 1.1: Organisational approaches to trauma management

Pre-incident activities	Assessing risk of exposure to trauma
	Selection and recruitment activity
	Training and preparation of employees
	Security measures and practices
	Setting expectations for customer/client behaviour
Procedures during an incident	Avoiding confrontation
	Control and restraint techniques
	Major disaster plans
Post-incident response	Crisis management
	Same day defusing
	Psychological debriefing
	Longer term psychological support

Source: IES

Models of debriefing first emerged in the early 1980s from two practitioners working independently – Mitchell and Dyregrov. Developed originally as a group intervention for emergency service personnel, the goals for critical incident stress debriefing as proposed by Mitchell (1983) were to:

1. mitigate the harmful effects of traumatic stress on emergency personnel
2. accelerate normal recovery processes in normal people who were experiencing normal reactions to abnormal events.

Mitchell believed that critical incident stress debriefing would be an important factor in the prevention of PTSD and post-traumatic stress in high-risk occupational groups.

Rose et al. (2002) describe psychological debriefing in the following way:

> *'Most workers consider a PD [psychological debriefing] to be a single-session, semi-structured crisis intervention designed to reduce and prevent adverse psychological responses to the traumatic event.'*
>
> ('History, methods and development of psychological debriefing', in: *Professional Practice Board Working Party report on Psychological Debriefing P2*, British Psychological Society)

Models of debriefing were originally developed for use in groups (see Table 1.2). Since the first models of debriefing put forward by Mitchell and Dyregrov, others have developed. Rose (op cit) presents the following comparison of four 'current and popular' models of group debriefing.

All propose a similar structure involving a series of phases through which the debriefing progresses. In all cases, the debriefing model, as part of the process, involves each participant in intense re-exposure to the event through having each person identify what for them was the most traumatic aspect of their experience and the identification of their personal symptoms of distress.

Table 1.2: Models of debriefing

Mitchell Introduction/rules	Dyregrov Introduction/rules	Raphael Introduction/rules	Armstrong et al. Introduction/rules
Facts	Expectations and facts	Initiation into disaster	Identification of events
Thoughts	Thoughts and decisions	Experience of disaster	Feelings and reactions to difficult events
Reactions	Sensory impressions	Negative/positive Aspects and feelings	
Symptoms	Emotional reactions	Relationship with others	Coping strategies, past and present coping strategies
Teaching	Normalisation	Feelings of victims	Termination
Re-entry	Future planning/coping	Disengagement	Focus on leaving the disaster and returning home
	Disengagement	Review and close	

Source: Rose et al (2002)

1.4.2 The evidence base for psychological debriefing

What research had been done by the late 1990s focused almost exclusively on psychological debriefing/critical incident stress debriefing as opposed to other forms of support. Studies of debriefing tend to fall into one of two categories, either they are:

- randomised controlled trials (RCTs) of the effects of debriefing on trauma symptom levels, or
- evaluations of debriefing with no randomised control condition. They may well report on symptom levels, but also focus on other non-clinical outcomes such as acceptability of, and satisfaction with the intervention.

1.4.3 RCT studies of debriefing

A review of the scientifically most robust evidence (ie RCTs) of the impact of single session 'debriefing' on trauma symptom levels (Wessely, Rose and Bisson, 1998) concluded that the use of individual debriefing could not be recommended and findings from one study indicated that debriefing had an adverse effect on those in the intervention group.

Since this early Cochrane review of evidence further updates, as new RCTs are published and added to the review (Rose, Bisson and Wessely, 2002; Rose, Bisson, Churchill and Wessely, 2006), have served only to strengthen the original conclusions about the use of debriefing for victims of trauma. Other reviewers have come to similar conclusions indicating that psychological debriefing at best has no effect on trauma symptoms and at worst might be harmful for some individuals (Devilly and Cotton, 2003; van Emmerik et al. 2002).

In March 2005 the National Institute for Clinical Excellence (NICE) produced a guideline on the management of PTSD in adults and children in primary and secondary care which states that debriefing should NOT be routine practice when delivering services.

> *'For individuals who have experienced a traumatic event, the systematic provision to that individual alone of brief, single-session interventions (often referred to as debriefing) that focus on the traumatic incident should not be routine practice when delivering services.'*
>
> NICE: Clinical Guideline 26, March 2005, p.16.

1.4.4 Non-RCT studies of debriefing

On the whole, non RCT studies of debriefing have consistently reported that the interventions are valued by recipients and employers alike, but have failed to demonstrate a positive improvement in trauma symptoms. Tehrani (2002), in a professional practice board working party report for the British Psychological Society on psychological debriefing concluded that research to date had failed to prove that psychological debriefing was effective as an early intervention following traumatic exposure. The working party called for further research in this area.

1.5 Debriefing and the implications for organisations

While the findings from RCTs clearly oppose the continued use of debriefing from a research perspective, many practitioners remained committed to what they saw as a valuable and much needed intervention from a practice perspective, despite the lack of evidence to demonstrate a positive effect of debriefing on trauma symptoms. Such circumstances gave rise to a polarised and often bitter debate about whether PB or critical incident stress debriefing exacerbated rather than reduced traumatic symptoms. Consequently there was little clear evidence for organisations what they could or should do to best manage workplace trauma.

The cumulative weight of evidence against the use of debriefing coupled with a dearth of evidence about other forms of trauma management represent a real and pressing need for evidence-based advice about safe and effective ways to provide support to employees post trauma.

1.5.1 If not debriefing, then what?

Watchful waiting

The NICE guidelines on the management of PTSD recommend for primary and secondary care providers to engage in 'watchful waiting' (based on evidence collected from expert committee reports or opinions and/or clinical experiences of respected authorities). In a medical context watchful waiting describes an approach to a medical

problem in which time is allowed to pass before further testing or therapy is pursued. Watchful waiting is recommended most commonly in situations where:

- there is a high likelihood of self-resolution or
- the risks of a therapy potentially outweigh its benefits.

Watchful waiting, while appropriate for medical settings where health care professionals are available to monitor and test for symptoms, is a less practical approach within organisations: the well-being of employees cannot be monitored in the same way as that of patients and appropriate healthcare professionals are not always available to monitor and further test employees in the same way.

Also, healthcare providers are focused on the needs of the individual patient and to some extent their families. For organisations there are a number of different needs to consider in addition to those of the individual employee. These include colleagues and managers among others and in some circumstances the continuation of services (eg to the public).

Practical, social and emotional support

The NICE guidance also notes that *'practical support delivered in an empathetic manner is important in promoting recovery for PTSD'* and that staff should offer practical, social and emotional support to those involved (recommended good practice based on the clinical experience of the guideline development group).

This recommendation lends itself far more obviously to adaptation for an organisational setting. It also concurs with much of the non-symptom based/non-RCT research into debriefing, which commonly claims a range of practical and social benefits arising from debriefing.

It has been suggested that one of the reasons debriefing remains popular among some practitioners is that it appears to fulfil many other individual and organisational needs. Raphael et al. (1995) characterised this as follows:

For those who have experienced trauma:

- the opportunity to articulate and understand what is happening
- to feel reassured that any symptoms they are experiencing are normal reactions to an abnormal situation

For co-workers and managers:

- display concern for colleagues
- deal with feelings of helplessness and survivor guilt
- deal with their own (vicarious) feelings of trauma

From the research it seems reasonable to conclude that, while having a meeting for staff affected by an incident, giving staff the opportunity to talk about the incident, providing information about symptoms and further sources of help may not reduce symptoms, these can form a valued organisational response for other reasons. However, if this happens within the context of a debriefing session which involves intense emotional re-exposure to the incident, then research indicates that there is a real risk of harm to the individual through increased symptoms in the longer term.

1.5.2 A framework for meeting organisational needs

For organisations, then, the need is to have in place some form of trauma management procedure which acts as a mechanism for the delivery of practical, social and emotional support and:

- does not risk the health of the employee through intense emotional re-exposure to the traumatic incident
- meets the needs of the employees with regard to support and information
- meets the needs of colleagues
- meets the needs of managers enabling them to provide appropriate support.

It has been proposed that, within an organisational setting, an adapted form of debriefing, in which information giving and support is emphasised and the emotional re-experiencing element removed, could be a useful mechanism by which organisations could deliver appropriate support (Rick et al 1998; Rick and Briner, 2000).

Others have suggested the areas that should be addressed by workplace interventions but not specified the mechanisms by which this support could be delivered. For example, Devilly and Cotton (2003) provided a set of guidelines for workplace traumatic stress responses. Their guidelines were, in some respects, specific to legal requirements in Australia but included the following generic principles:

- up-to-date research based organisational policy
- access to immediate practical and social support
- provision of factual information and normalisation of reactions (not 'symptoms')
- promote proactive problem solving
- monitor staff to identify at-risk individuals
- provide access to early intervention for individuals who report enduring distress
- ensure appropriate organisational liaison and feedback.

Devilly and Cotton proposed that these guidelines were not seen as prescriptive, but rather as suggestive of approaches that could be taken as a template and adapted to the specific needs of the organisation and event.

We are not aware of any evaluations of organisationally driven trauma management programmes as described in this section. These approaches are based on expert opinion of what will be beneficial rather than evidence of what is effective.

1.6 The current research

At the time of commissioning, the BOHRF was responding to a very real need among organisations for research evidence to address these gaps in knowledge and specifically to provide evidence about which forms of trauma management work best in an organisational setting. The current research, hosted by a partnership between Royal Mail Group (RMG) and Atos Origin (AO) and funded by a consortia of organisations, sought to address these gaps.

1.6.1 Research aims and objectives

This research seeks to answer a number of important questions in a growing area of concern for occupational health practitioners. Its 'real world' occupational setting gives this project some unique strengths in comparison to much previous research in the area.

Research aims

Broadly speaking, the aims of the current research were threefold:

- to move beyond the perceived deadlock over the evidence on debriefing by examining trauma management from an organisational perspective
- to address the gaps in the knowledge about appropriate strategies for workplace trauma management
- to provide robust evidence from an organisational setting on which practical advice can be based.

The primary objective of the research was to answer the question:

> *What can organisations do for employees post trauma that is both safe and effective?*

Initial scoping exercise

At the start of the research, a scoping exercise was undertaken within RMG. The outcomes of this suggested that it would be possible to study the effects of a range of interventions including:

- crisis management/defusing
- manager debriefing
- critical incident debriefing
- eye movement de-sensitisation and reprocessing.

However, between the scoping exercise in 2000 and the commencement of the main study in August 2002, a major organisational change took place. Many existing trauma management practices were no longer operating in the new structure and since 2002 a new programme of manager training has been rolled out. This ultimately became known as the Support Post Trauma (SPoT) manager protocol.

This had two main implications for the study:

- the nature of intervention during the follow-up period changed
- during the study period some employees attended SPoT meetings with trained managers, but where there were no trained managers, others did not. While by no means a random allocation to treatment or control group, the circumstances of a new intervention being rolled out did allow us to compare SPoT and non-SPoT recipients in conditions relatively free from bias.

Also, some employees were offered further support via a specialist trauma counselling service provided by AO.

Research objectives

Specifically, the research objectives were to:

- identify employees and franchise holders within RMG exposed to (objectively defined) potentially traumatic incidents
- track these employees over a 13 month period measuring symptoms, organisational support, attitudes/satisfaction and absence
- assess the immediate impact of events for all those involved in an incident
- assess the impact of defusing, SPoT meetings and trauma counselling respectively on the levels of reported symptoms, absence and satisfaction with support
- identify any issues for the management (as opposed to the treatment) of PTSD in the workplace.

This research sought to build on previous research findings in a number of ways: primarily, unlike many previous studies, the research took place in a work setting and:

- involved all employees who experience a potentially traumatic experience as opposed to only those sustaining physical injuries as well (eg admissions to A&E or a burns unit as in examples of previous research)
- focused on work-based incidents and responses and is therefore directly relevant to organisations and occupational health counselling services
- covered a wide range of occupations and types of incident, so findings are relevant to many different occupational settings
- considered the management of events as well as the treatment of symptoms, so integrating the dual role of occupational health counselling to provide responses in a work context.

The next chapters go on to describe the methodology and sample in detail and then results from the research in relation to respondent satisfaction with organisational support and its impact on symptom and absence levels.

Key points

- Employers are increasingly concerned about the impact of certain severe stressors on employees.
- Employer responsibilities are clear and enshrined in law. Evidence for good practice on how to manage such events is less clear, leaving many employers with little or no guidance on what to do for the best.
- Many people spontaneously recover from traumatic incidents but a significant minority (typically around 25 per cent) will not and will benefit from continued support. However, this figure varies considerably depending on the nature of the trauma.
- Much organisational activity to manage traumatic events is based on anecdotal evidence or organisational consensus. Little research evidence exists to date about what works best.
- One commonly used approach with wide appeal is that of psychological or critical incident stress debriefing.
- Despite its popular appeal, the best research evidence on debriefing says that at best its effects are neutral and at worst it can have negative outcomes for individuals – NICE now recommends against the use of debriefing.
- 'Watchful waiting' – the recommended approach in health settings post trauma, is difficult to deliver in other organisational contexts. However, organisational strategies for delivering practical, social and emotional support are easier to envisage.
- Taking into account the best research evidence and guidance available we propose that a framework is needed for the provision of support to meet individual and organisational needs post trauma.
- The research seeks to describe that framework by presenting evidence on what organisations can do for employees that is both safe and effective.

2 Methodology and Research Process

2.1 Description of the organisation

2.1.1 Royal Mail Group

RMG[1] is the largest organisation in the UK outside the NHS with approximately 200,000 employees in a variety of business units. Work ranges from delivering mail to householders, through handling high cash value items in secure vans, to serving customers from Post Offices in the high street. Virtually every type of job role is represented somewhere in the organisation.

Traumatic incidents are unfortunately a common occurrence given the scale and complexity of the organisation. For instance, there is a huge infrastructure that includes trains, airplanes and cars/vans/lorries, which creates a potential for having or creating accidents. Also, Post Offices are available in almost every town or village and are more numerous than all the banks and building society outlets in the UK combined. These offices deal with large sums of money and armoured vans (run by the cash handling business) transport the money. Both are subject to increasingly savage bandit attacks and hostage taking.

2.1.2 Trauma care programme

RMG's businesses have run a trauma care programme over the past ten years. The programme has changed and developed over time and, in its current form, consists of three broad stages.

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[1] In 2001, shortly after the current phase of research was begun, the Post Office became Consignia and, in 2002, Royal Mail Group, during a period of substantial organisational change. We will refer to the group of businesses as RMG throughout the report.

Stage one

Crisis management and defusing – this takes place on the day of the incident. The aim of crisis management/defusing is to ensure that employees are offered appropriate support in dealing with the practicalities of any incident. This could involve taking over if the individual is unable to continue working (and ensuring that they are not returning to an empty home) or assisting in reporting the incident, securing premises and dealing with police and security services.

Stage two

SPoT protocol[1] is normally conducted within three days of the incident. SPoT protocol involves a voluntary meeting with a specially trained manager. The aim of the meeting is to ensure that appropriate management support to the employee is maintained. The meeting follows a standard structure and provides an opportunity to talk through the facts of the incident, to provide information to the employee about symptoms they might experience post trauma and to give details of further support services within the organisation. The SPoT manager can also offer the employee an appointment with the professional counselling service.

Table 2.1 shows the main differences between SPoT and psychological debriefing.

Table 2.1: Characteristics of SPoT and psychological debriefing

	SPoT	Psychological debriefing
Delivered by?	Managers	Health care professionals
Intense re-exposure of feelings?	No	Yes
Follow up with counselling?	Yes, SPoT manager identifies cases requiring counselling input. SPoT is part of an overall package of trauma support	No, traditional models have been criticised as being 'one off' debriefing sessions
How are line management issues tackled?	SPoT manager provides reassurance that individual has followed organisation's procedures if this is relevant	Debriefer does not comment on organisational procedures

Training of managers in the SPoT protocol occurs over a rigorous two-day training programme. Recruitment of suitable managers is strict to ensure that they are likely to have the right attitudes and skills to pass the assessed training course. Therefore all managers need to demonstrate that they:

- have used counselling skills in their role
- are substantive managers (ie not 'acting up')

[1] Throughout the data collection phase of this research, the second level of support (ie SPoT protocol) was commonly referred to as a manager debrief within the businesses. Over the course of the research, the intervention has been renamed to better reflect the nature of the meeting and support offered.

- do not have any performance or conduct issues on their record
- are able to be released to conduct the SPoT meetings
- are willing to be assessed as competent in the training.

The two-day training covers the following areas:

- Legal and business context – clarifying the position of crisis response and management in the context of organisational responsibility to provide safe place of work and duty of care. Discusses the social context of increasing violence in society and the financial cost of trauma to individuals and organisations with personal injury litigation as one of the drivers.
- RMG policy and process – clarifying organisation policy and processes relevant to crisis management. This will include who does what, when, and how, in the event of a major event affecting people in the workplace.
- Understanding trauma – explanation of the physiological/psychological/emotional and behavioural impact of trauma.
- SPoT protocol – introduction to the protocol structure, practice using specially designed case studies, assessment of each delegate using the SPoT protocol with verbal and written feedback.
- Listening and responding skills – introduction to listening and responding skills including response styles, venting, normalisation, verbal and non-verbal cues, use of open/closed/one word/leading/multiple questions. Matching, mirroring and leading. Linking trauma to grief/loss/major change.
- Support services via OH – outlines support services available, how and when to access.
- Self care – understanding impact on self of listening to traumatic story and promoting recognition of need to have support plan ie debriefing with colleague or time out to recover own perspective.

By the end of the course successful SPoT managers will:

- be able to explain the employer's legal duty of care in the context of a traumatic event
- be able to list the two symptoms from each of the three main PTSD symptom groups involved in traumatic stress
- be able to summarise the organisation's crisis management and trauma support process
- have demonstrated competence using SPoT protocol showing appropriate listening and responding skills

- be familiar with sources of support for traumatised individuals
- have identified in an action plan three practical steps to support own self-care when dealing with traumatic incidents.

Stage three

Further support is available via the professional trauma counselling service. This includes:

- Initial counselling (previously known as critical incident debriefing [CID]). Initial counselling usually stars with an in-depth assessment about the nature of the trauma and, where needed, they adopt the model devised by Tehrani and Westlake (1994) as a way of understanding what happened. The sessions normally occur within 14 days of the incident, last for 90 minutes and all are followed-up within two weeks with further support.
- Trauma counselling, which is a four to six session model of counselling for those who have persistent traumatic symptoms. AO's employee assistance programme is used as a back-up resource where, for example, there are legal or social/domestic issues that need support or where more extended trauma counselling support is required.
- In exceptional cases, practitioners have the option of referring employees to a five-day intensive trauma rehabilitation course.

2.1.3 Availability of trauma support within RMG

Before the research started a major audit was undertaken of RMG incident reporting and trauma reporting systems. It was apparent from this audit that not all incidents in which employees could be exposed to trauma were being consistently reported to the occupational health providers.[1]

Also RMG was aware that, although trauma management procedures had been put in place in areas where there is a high likelihood of being attacked (such as those roles where employees had access to large amounts of money, which attracted crime or because of the location of their work, ie a high crime area), there was evidence that procedures were not being followed. They had largely ceased because of staff changes and the transfer of trained managers to other jobs (as part of larger organisation wide change).

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[1] Employee Health Services were provided in-house at the start of this research but were later outsourced, initially to Schlumberger-Sema which was acquired by Atos Origin. The services are currently provided under Atos Origin's occupational health. For ease of reference, we will use the generic term of OH.

As a result between 1999 and the present date, RMG has undertaken a major programme to train selected managers in the SPoT protocol. In addition, to address the possible under-reporting of incidents, RMG and OH have established a dedicated incident reporting telephone line. Incidents are now reported to OH at the same time as they are reported to the security services within Royal Mail.

2.2 Research process

There are three key aspects of the research process which contribute to the robustness of the methodology:

- Participants were recruited to the study on the basis of their exposure to an objectively pre-determined incident type.
- The roll-out of SPoT protocol training meant that the research was able to take advantage of a naturally occurring change within the organisation, which provided a control condition for the intervention.
- The establishment of a telephone helpline and OH tracking database meant that independent data on counselling interventions could be collected for each employee identified as eligible for the study as well as the independent employee absence data available from RMG.

2.2.1 Identifying traumatic incidents

Following liaison between the OH and RMG, RMG's business unit representatives and the Institute for Employment Studies (IES), an agreed definition of trauma was drawn up as:

> *'Any work-related incident where the individual experiencing it perceives the event as traumatic. This extends from actual verbal violence to threats of physical attack of self or others. It includes witnessing an incident.'*

A previous audit of the trauma incident reporting procedures within RMG meant that employees exposed to certain types of incident defined within existing reporting procedures could be identified for inclusion in the study. The incidents included:

- dog attacks
- accidents, falls and RTAs
- physical assaults
- robbery/attempted robbery
- armed robberies, hostage situations and ram raids.

Employees were therefore recruited to the study on the basis of their exposure to an objectively determined potentially traumatic incident rather than on the basis of their own self report or symptom levels.

2.2.2 Notification of incidents

Different methods of notification were drawn up with each business unit by OH. These were trialled and then formally agreed before the data collection started, although some organisational changes occurred during the data collection phase which had an impact on the notification process. The notification methods can be split into two general groups: participating RMG businesses and non-participating RMG businesses.

Participating trauma care policy businesses

These participating businesses ensured that all managers were fully aware of their responsibilities to report any traumatic incident to a central helpline point that was available 24 hours, seven days per week. This internal helpline records all incidents that take place and arranges crisis management/defusing as well as informing security and audit functions. Only incidents that met the agreed definition of trauma were forwarded onto the OH provider for inclusion on the trauma tracking database.

Non-participating trauma care policy businesses

For the non-participating businesses, traumatic incidents were collected using the organisation's existing *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995* system within the accident management unit. Each incident which met the criteria for inclusion into the research was forwarded to OH and tracked from there. The range of incidents covered is included below:

- dog bites – these would not all be captured but the worst injuries would be
- employee deaths
- member of public fatality or serious injury because of actions of RMG employee
- accidents at work which cause serious physical injury
- other incidents such as explosions or other threats to the integrity of employees
- serious physical assaults
- hold-ups/robberies with guns/knives – these are only included if injuries are serious.

In general, the number of incidents reported through the latter pathway was much lower than through the helpline.

Notification of incidents from RMG's businesses to the researchers at IES was facilitated by RMG's OH service. At the start of the research project employee health and support services were provided in-house and later via SchlumbergerSema and most recently AO. However, staff involved in passing on information on incidents to the researchers remained the same throughout the duration of the project, which helped ensure the smooth running of this process throughout the research period.

2.2.3 Recruitment to the study

The OH incident reporting line received details of all incidents within RMG that met the agreed criteria for the definition. The research process was as follows:

A traumatic incident occurs within a RMG business, then:

1. the incident is reported to OH for tracking
2. OH notifies IES with details of new[1] incidents
3. IES checks that the incident meets the research criteria[2] and sends out a questionnaire immediately
4. IES sends out reminders and follow-up questionnaires as planned based on the date of the original incident
5. objective data is collected from RMG on outcomes of people included in the study for the period of 13 months post-incident.

2.2.4 Controlled comparison

The roll-out of SPoT protocol training meant that the research was able to take advantage of a naturally occurring change within the organisation. As a result, comparison groups were available from two sources within the data:

- businesses not participating in the trauma care service
- businesses within the trauma care service arrangements, before receiving manager training in the use of SPoT protocol.

2.2.5 Longitudinal element

Initially each potential participant was sent a questionnaire with a covering letter from IES and a prepaid envelope. A further introductory letter from RMG was

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[1] new and those that have occurred recently

[2] Criteria for inclusion into the research is that the incident must have taken place within the past five days and the worker has not already been included in the study because of a previous incident.

included at time 1 which introduced IES and referred to the support lent to the study by the Communication Workers Union (CWU) and the Communication Managers Association (CMA). The time 1 questionnaire included an opt-out tick box providing potential participants with an additional opportunity to opt-out of the study. Potential participants who did not respond were sent a reminder letter two weeks later with a spare questionnaire.

Potential participants were posted a time 1 questionnaire within 48 hours of an incident being notified to IES and always within five days of the incident occurring. Those who did not opt-out at this first stage or by other informal means (eg telephone call) were posted a time 2 questionnaire three months from the date of the incident. And again those who did not reply within two weeks were sent a reminder letter and spare questionnaire.

Potential participants were posted a time 3 questionnaire 13 months following the incident, with a reminder letter and spare questionnaire posted two weeks later to those who did not reply or opt-out of the study.

2.2.6 Types of data collected

Four general types of data were collected in the course of the research:

- incident data
- self-report data at three time points
- objective outcome data
- intervention data.

Incident data

A total of 837 were recorded as leads to potential research participants. Some basic details were recorded about each incident, the date the incident took place, the general type of incident which occurred (eg attempted robbery) and the contact details of the person who experienced or witnessed the incident.

Self-report data

A total of 458 replies were returned from survey participants on at least one of the three different time points and 120 replies were returned at all three time points. The types of questions raised in the three questionnaires are presented in Table 2.2. All three questionnaires included self-report data on their reaction to the incident, the levels of social support available to them, their physical and emotional health, and their experience of other incidents since the 'trigger' incident. The revised impact of events scale (IES_R) was also included at all three time points. A copy of the time 1 questionnaire is at Appendix 1.

Table 2.1: Contents of questionnaires

Measure	Description
Physical Functioning	The extent to which daily activities are restricted by physical health
Emotional Functioning	The extent to which daily activities are restricted by emotional health
IES-R	Symptom levels on the three main symptom clusters associated with PTSD
28 item version of the general health questionnaire (GHQ-28)	Domain free measure of minor psychiatric morbidity
Social Support	Brief measure of degrees of emotional support available
Trauma screening questionnaire (TSQ)	Brief measure to identify those at risk of health problems in the longer term.

Source: IES

Objective outcome data

Basic outcome data for workers was provided by RMG after the survey phase of the project. For employees this took the form of sickness absence data in the 12 month period following the incident. For franchisees it took the form of contract status 12 months following the incident. Data for employees of franchisees was obviously not available as RMG has no direct link to such individuals and other workers could not be traced. In all, outcome data was available for 474 individuals.

Intervention data from secondary sources

Some basic intervention data was also provided from OH services as well as that which was reported in the survey. Specifically, data on whether the worker had received trauma counselling or further counselling in the year following the incident was also provided. This data was available for all but ten of the potential participants.

Table 2.3: Types of data collected

	Incident type	Absence	Contract status data	Survey data	Other intervention data
Respondent	RMG and PON staff	RMG staff	PON* staff	RMG and PON staff	RMG and PON staff
Non-respondent	RMG and PON staff	RMG staff	PON staff		RMG and PON staff

***** PON signifies Post Office Network

Source: IES

2.2.7 Databases

Trauma tracking

Staff from RMG's OH service provider maintained a trauma tracking database. All reported incidents were recorded whether the incident was the first, second or subsequent incident experienced by the individual.

All incidents were included as soon as they were notified to OH. On some occasions one incident was notified to OH via both systems: the business's internal helpline and the accident management unit, but OH ensured that the incident was recorded only once on the database.

The database was dual purpose: designed for conducting the research and to ensure follow-up support was made available to those who experienced incidents.

The OH service provider then supplied daily updates to the researchers on potential cases in the form of an excel spreadsheet, based on an abridged version of the trauma tracking database.

Survey administration

IES maintained an Microsoft Access database to manage the administration of the survey, which uses the individual worker as the main unit of recording. Only incidents which occurred within five days of notification to IES were recorded on the database.

Also, only the first incident experienced by a worker within the data collection period was recorded. Although it was quite common for potential participants to be involved in subsequent incidents, it was important to avoid an additional set of questionnaires being sent to the individual who was already participating in the study. Information of additional incidents was collected in the surveys.

The main purpose of the database was to ensure reminders and follow-up questionnaires were sent at appropriate times in relation to the original incident.

2.3 Sample description

2.3.1 Businesses and occupations

Incidents which occurred in three businesses of RMG were included within the scope of the study:

- cash handling and delivery (CHD)
- service delivery
- Post Office Network (PON).

The study included both direct employees of RMG (ie who worked in CHD, service delivery, or within Post Office branches), and members of PON who operate their own businesses under franchise from the Post Office. (It should be noted that a portion of the Post Office business will comprise employees as they are Crown Offices.)

The occupations therefore include people engaged in collecting, sorting and/or delivering mail and parcels; drivers and couriers involved in collecting and delivering valuables to/from post offices and other businesses; counter staff and owner-managers of post offices. In the main, branches operated directly by RMG are larger and more likely to be city-centre based than those operated by franchisees. Because of a number of factors, such as their location, these premises are less vulnerable to raids and robbery than small post offices based in villages. As a result, the majority of post office counter staff who participated in the study were engaged in PON either as owner-managers or occasionally as employees of these small businesses.

Of the 837 potential participants that were identified and invited to take part in the study, 59 per cent were employed in post office counters or networks, 36 per cent were employed in service delivery and five per cent were employed in CHD.

2.3.2 Types of incident

A high proportion of incidents occurring during the data collection period included robberies, attempted robberies, armed robberies and hostage situations, as can be seen in Table 2.4. This it is not surprising given that over half the potential sample was made up of workers in the post office side of the business. Dog attacks, physical assaults and accidents, falls and RTAs are more associated with service delivery activities, and therefore the numbers of workers from that area of the business reflect this distribution of incidents.

During the early part of the research, the researchers noticed that a high proportion of reported incidents involved dog attacks, but that the response rate to the survey from people involved in such incidents was very low. The researchers were aware that the notification process for such incidents did not systematically distinguish between very minor dog bites and severe dog attacks where dogs were used as weapons by attackers or where the worker sustained significant injuries. The researchers suspected that many of the dog-related incidents were not perceived as potentially traumatic by the workers involved and so the survey was considered irrelevant. This was confirmed by informal responses from such workers. As a result, the researchers decided later in the project only to include dog incidents which involved significant injuries or other indicators of severity.

Table 2.4: Types of incident

Type of traumatic incident	Total	
	No.	%
Dog attack	200	24.5
Accidents, falls and RTA	46	5.6
Physical assaults	61	7.5
Robbery/attempted robbery	200	24.5
Armed robberies, hostages and ram raids	308	37.8
Total	*815*	*100*

Note: missing cases = 13

Source: Survey administration database

2.3.3 Data collection period

Regular reports from the trauma tracking database were forwarded from the end of August 2002 through to the end of September 2004 when the recruitment phase of the project was closed. First stage questionnaires were distributed to 837 potential participants. A decision was taken to close recruitment to the study in September 2004 when 400 first stage questionnaires were returned.

Each individual was then followed-up with questionnaires at three and 13 months, the last follow-up taking place in October 2005. Outcome and intervention data for a 12 month period following the incident was collected for the entire sample at the end of the survey collection phase.

2.3.4 Design modifications

During the course of the research a number of substantial organisational changes occurred at the host organisation. Inevitably these major organisational changes had an impact on recruitment to the study and data collection. Although OH personnel remained the same throughout the study period, wider contacts within the organisation (identified during the scoping study) were lost or changed roles. The net effect was to slow down recruitment to the study, with some parts of the business (eg CHD) only coming on stream in the latter stages of the study.

Also, RMG's trauma care programme has been adapted and developed in response to new latest research in the area. Applied research will always face these challenges and, where there are implications for the analysis, these are made clear in the text.

2.3.5 Intervention groups

As described in Section 2.1.2, the RMG trauma care programme consists of a three-stage approach in which workers are offered progressive levels of support according to need. Employees would therefore fall into one of four groups:

- no intervention (ie control group) – survey respondents at time 1 who report no evidence of crisis management/defusing
- crisis management/defusing
- SPoT (sometimes known by workers as a manager debrief)
- counselling support by occupational health counselling professionals.

The participation rates in different types of support are described in detail Chapter 4. In short, while crisis management and SPoT are relatively common (experienced by 37 and 39 per cent of survey respondents respectively), professional counselling is relatively rare. The focus of the analysis in Chapter 5 therefore concentrates mainly on these more common forms of support. The next chapter goes on to discuss the sample in more detail.

Key points

- RMG is the largest employer in the UK outside of the NHS, with virtually all job types occurring within the organisation.
- Exposure to trauma arises both through incidents that occur in many jobs (eg, a fall or a road traffic accident) and through incidents more specific to the nature of the job (ie cash handling).
- The RMG trauma management programme was introduced ten years ago and has evolved to its present day format which constitutes three phrases: practical support on the day in the form of crisis management; a SPoT protocol designed to ensure managers provide appropriate practical, emotional and social support; and further ongoing support from the professional trauma counselling service.
- Organisational changes within RMG meant that the trauma management programme had lapsed in part of the organisation. Before the research began, RMG rolled out a new manager training programme to selected managers to ensure that appropriate social, practical and emotional support was offered to employees (this become known as the SPoT protocol).
- A robust research design was adopted, where all employees exposed to a range of pre-determined incident types (eg RTA, armed raid etc) were included in the study and tracked for 13 months.
- Questionnaires were sent at three time points: Immediately post incident, at three months and at 13 months.

- Objective data on incident type, absence, contract status and OH further support were collected direct from the organisation for all relevant employees identified as experiencing an incident.
- The final research sample included employees from three main areas: CHD, PON and service delivery.
- Types of incidents were wide ranging and included robberies, attempted robberies, armed robberies, hostage taking situations, dog attacks, physical assaults, accidents, falls and RTAs.
- Participants were recruited to the study between August 2002 and September 2004. The final 13 month follow-up questionnaires were marked out in October 2005 and the survey closed in January 2006.
- RMG underwent a number of changes during this period. Where these have implications for the research they are noted in the text.

3 Sample Description

This chapter is principally about how the achieved survey sample relates to non-respondents to the survey. We look at the response rates and drop out rates, compare respondents to non-respondents, consider the incidents and businesses included in the study and the personal characteristics of those who responded. It serves as a background to the subsequent chapters where we consider the connections between each of these variables.

3.1 Survey response rate

Decreasing response rates are the result of a number of factors such as respondents moving job or leaving the organisation.

In total 837 individuals identified by incident and who did not opt out of the survey were tracked for a 13 month period, receiving questionnaires immediately post incident and at three and 13 months post incident. A total of 458 (55 per cent) potential participants responded at one or more time points in the survey. The largest single response was obtained at time 1, where data was obtained for 48 per cent of the potential sample. As to be expected, response rates dropped over the follow-up phases, but remained relatively high for a survey of this kind. It should be noted that no adjustment has been made for drop out, although attrition of employees through normal turnover would equate to about ten per cent per annum and 42 per cent of non-RMG employees left the organisation or had their contract terminated in the year following the incident.

Table 3.1: Number of cases responding at individual stages of the survey

	No		Yes	
	N	%	N	%
Did respondent answer time 1 questionnaire?	438	52.3	399	47.7
Did respondent answer time 2 questionnaire?	567	67.7	270	32.3
Did respondent answer time 3 questionnaire?	657	78.5	180	21.5
Total N = 837				

Note: Missing cases = 0

Source: IES survey

As shown in Table 3.2, 14 per cent of the potential sample responded at all time points in the survey. Thirty-two per cent of cases responded at two or more time points.

Table 3.2: Number of cases responding at different stages of the survey

Time point	N	%
None	379	45.3
Time 1 only	139	16.6
Time 2 only	38	4.5
Time 3 only	10	1.2
Times 1 and 2	101	12.1
Times 1 and 3	39	4.7
Times 2 and 3	11	1.3
All three times	120	14.3
Total	*837*	*100*

Note: Missing cases = 0

Source: IES survey

3.2 Outcomes of survey respondents and non-respondents

In this section we briefly report on some of the outcomes for both survey respondents and non-respondents. For employees of RMG (mostly working in CHD and service delivery) this took the form of sickness absence in the year following the incident. For PON franchisees this took the form of contract status. Outcomes are reported fully in Chapter 5, our intention here is simply to consider whether outcomes for survey participants differ significantly compared to non-respondents. The section is therefore necessarily restricted to those outcomes which are available for all potential participants (ie based on RMG data) and does not include the self-reported outcomes of survey participants.

3.2.1 Absence data for Royal Mail employees

Absence data was collected for the 12 months post incident direct from RMG for all employees identified as eligible to participate in the research. Absence data has a non normal distribution and therefore non parametric tests of significance were applied. Statistical analysis failed to show a significant relationship between the number of days absent, or the number of times absent and the propensity of employees to respond to the survey (see Table 3.3).

Overall, the number of periods of absence ranged from zero to 11 over the course of the year, with the most common pattern being two absences among both groups. The number of days absent did not follow a normal distribution and the mean, median and mode averages for the whole sample were 22, eight and zero respectively. Although the mean average number of days differed between respondents and non-respondents, the median and mode averages were very similar across the two groups.

Table 3.3: Cross tabulation of survey response rate and sickness absence

	Did not respond to survey at any time		Responded to survey		Total
	N	Median days[6]	N	Median days	N
Times absent in year following incident	118	2	172	2	290
Number of days absent in year following incident	118	7	172	9	290

Note: Missing cases = 0 (data available for RM-employees only)

Source: IES survey and RMG

3.2.2 Contract status of PON franchisees

Contract status was not a significant factor in non-employees' likelihood to respond to the survey as a whole. However, contract status appeared to influence propensity to reply at time 3. Seventy-two per cent of respondents at this stage were 'active' compared to 53 per cent of non-respondents perhaps reflecting contact difficulties with leavers. However, this difference was not statistically significant.

Overall, of the 184 non-employees for whom Royal Mail held data, 57 per cent of the sample were still active, 27 per cent had resigned and 17 per cent had had their contract terminated in the year following the incident.

[6] Given the nature and distribution of absence data, a simple comparison of averages between the respondents and non-respondents would not be appropriate.

Table 3.4: Cross tabulation of survey response rate and contract status

	Did not respond to survey at any time		Responded to survey		Total
Current employment status	**N**	**%**	**N**	**%**	**N**
Active	48	55.8	56	57.1	104
Resigned	25	29.1	24	24.5	49
Dismissed/end of contract/redundancy	13	15.1	18	18.4	31
Total	*86*	*100*	*98*	*100*	*184*

Note: Missing cases = 0 (Non-employees only)

Source: IES survey and RMG

3.3 Types of businesses and incidents included in the survey

3.3.1 Business areas

The survey sample included a significant proportion of employees working in all three business areas of RMG. The potential sample of CHD staff invited to take part in the study was notably smaller than the other two groups.

As shown in Table 3.5, employees working in CHD were slightly more highly represented in the survey than those from service delivery or PON. Though the effect size was small the difference was statistically significant. Increased propensity to respond to the survey may in part be owing to the consistently severe nature of incidents taking place within CHD; although very serious and dangerous incidents also take place in service delivery and PON, the range of severity within these businesses is much wider. Strong union presence in CHD may also be a factor, encouraging a high response rate compared especially to PON.

Table 3.5: Area of business and number of cases responding to the survey

	Did you respond at any time point to our survey?					
RMG area	**No**		**Yes**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**
CHD	14	32.6	29	67.4	43	5.2
Service delivery	125	41.8	174	58.2	299	36.2
PON	238	49.3	245	50.7	483	58.5
Total	*377*	*45.7*	*448*	*54.3*	*825*	*100*

Note: Missing cases = 0

Source: IES survey

3.3.2 Types of incident

The left hand column of Table 3.6 lists the main categories of incident as recorded within RMG. A breakdown of general incident types based on these categories can be seen in the right hand column of Table 3.6. This shows that employees experiencing a wide range of incidents were invited to take part in the study. The table also compares the incidents experienced by survey respondents with those experienced by non-respondents.

Table 3.6: Incident type and number of cases responding at different stages of the survey

	Did participant respond at any time point to survey?					
Type of traumatic incident	**No**		**Yes**		**Total**	
	N	**%**	**N**	**%**	**N**	**%**
Dog attack	94	47.0	106	53.0	200	24.5
Accidents, falls and RTAs	13	28.3	33	71.7	46	5.6
Physical assaults	21	34.4	40	65.6	61	7.5
Robbery/attempted robbery	105	52.5	95	47.5	200	24.5
Armed robberies, hostages and ram raids	139	45.1	169	54.9	308	37.8
Total	*372*	*45.6*	*443*	*54.4*	*815*	*100*

Note: Missing cases = 22, (2.6 per cent)

Source: IES survey and RMG

Analysis showed statistically significant but minor differences in response rates within incident type. Notably 72 per cent of individuals who had experienced an incident in the category 'accidents, falls and RTAs' responded to the survey. A high response rate is also observable for 'physical assaults' (65 per cent).

No type of incident is associated with exceptionally low response rates, although a relatively lower proportion of workers who had experienced 'robbery or attempted robbery' (48 per cent) responded to the survey.

3.3.3 Link between business type and incident type

The data shown in Table 3.7 demonstrate a fairly predictable link between business type and the likelihoods of different types of incident occurring. All dog attacks and the majority of 'accidents, falls and RTAs' occurred in a service delivery context. 'Armed robberies, hostages and ram raids' and 'robberies/attempted robberies' were more commonly seen in PON and CHD. This is included to emphasise that incident type and business area are fundamentally related.

Table 3.7: Cross tabulation of Royal Mail incident type by area of business

	CHD		Service delivery		PON		Total	
	N	%	N	%	N	%	N	%
Dog attack	0	0.0	200	68.3	0	0.0	200	24.5
Accidents, falls and RTAs	0	0.0	41	14.0	5	1.0	46	5.6
Physical assaults	6	14.0	37	12.6	18	3.8	61	7.5
Robbery/attempted robbery	21	48.8	5	1.7	174	36.3	200	24.5
Armed robberies, hostages and ram raids	16	37.2	10	3.4	282	58.9	308	37.8
Total No.	*43*	—	*293*	—	*479*	—	*815*	—

Note: Missing cases = 22, (2.6 per cent)

Source: IES survey and RMG

3.4 Personal characteristics of survey respondents

Survey respondents were asked a number of demographic questions at time 1. Not all survey respondents completed a questionnaire at time 1 and a small number of respondents who did so declined to answer the personal characteristics questions. However, here we briefly describe what we know about this sub-sample.

Fifty-eight per cent of these individuals were female. The sample was aged between 18 and 70 years old and was of an average age of 44 years. Ninety per cent described themselves as white. Six per cent of this sample reported a history of long-term health problems or a disability 'substantially limiting their day-to-day activities'. No equivalent information is available for survey non-respondents.

Key points

- Overall, 55 per cent of the potential sample responded at one or more time points in the survey and there drop out was relatively low during the course of the follow-up.
- There was very little difference between respondents and non-respondents in outcomes one year later, such as sickness absence levels or contract status.
- There was some response bias with regard to the businesses area/type of incident.
- All three business areas and a wide range of incidents were represented in the survey sample.
- The achieved sample is felt to be a good representation of all possible respondents and no significant differences between respondents and non-respondents, such as absence or contract status, were identified.

4 Incidents and Interventions

This chapter details the incidents experienced by survey respondents, the various types and levels of support offered and received by survey respondents, and their satisfaction with the organisational response.

4.1 The incident as reported by survey respondents

4.1.1 Main features of the incident

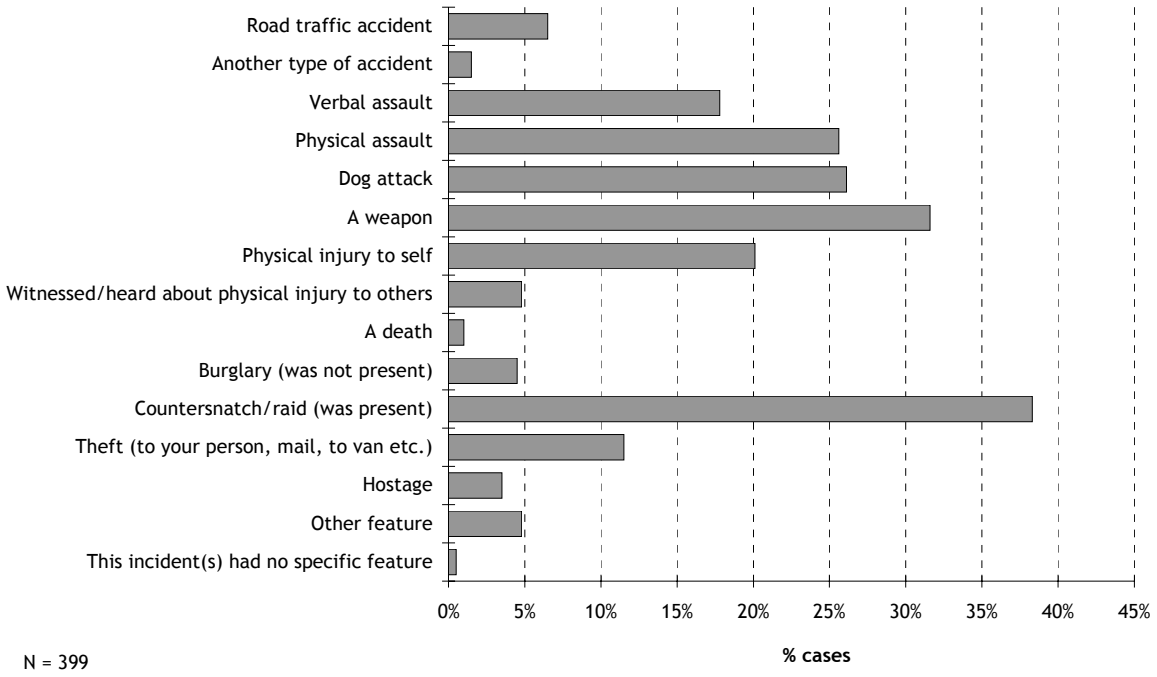
The time 1 survey asked respondents to identify the features of the incident they had experienced. This was included as a multiple response item to allow respondents to report multiple features for individual incidents.

Figure 4.1 shows that the most commonly reported features were 'a counter snatch or raid' (38 per cent), followed by incidents 'involving a weapon' (32 per cent), 'a dog attack' (26 per cent) and 'physical assault' (26 per cent). The pattern of features naturally reflects the categories of incident already described in Chapter 3. However, it is interesting to note that although physical assaults alone make up a relatively small proportion of the type of incidents included in the survey (nine per cent), physical assaults commonly feature in other types of incident (27 per cent). Twenty per cent of survey respondents were physically injured in the incident and five per cent witnessed a physical injury to someone else.

4.1.2 Surrounding circumstances of the incident

At time 1, 92 per cent of respondents said they had directly experienced the incident that they were involved in, while six per cent said they came across the scene afterwards, eg as might happen in a burglary situation. Only two per cent (seven individuals) had experienced the incident by hearing about it from somebody else. The majority (64 per cent) of respondents were working remotely when the incident occurred.

Figure 4.1: Incident type



Missing cases = 0

Source: IES survey

Of those who responded at time 1, 62 per cent were required to give a witness statement to the police or the Royal Mail investigator on the day. A further 11 per cent had to give a statement later. Just under half (43 per cent) either ended their shift early or closed their Post Office early on the day. Of the remainder, most continued to work their shift, though a small number, 11 per cent, happened to be at the end of their shift or working day when the incident took place. Leaving a shift early and being required to give a witness statement can be viewed as indicators of the severity of an incident, and Table 4.1 shows a fairly predictable pattern across the five types of incident.

Table 4.1: Early levels of support by incident type

	Dog attack		Accidents, falls and RTA		Physical assaults		Robbery/ attempted robbery		Armed robberies, hostages and ram raids		Total No.	Total %
	N	%	N	%	N	%	N	%	N	%	N	%
Required to give statement on day	19	19.2	9	32.1	22	68.8	63	76.8	120	87.0	233	61.5
Left shift early day /closed premises	15	15	7	31.8	13	52	35	47	76	66.1	146	43.3

Missing cases = 20 - 60

Source: IES survey

4.1.3 Perceptions of incident

When asked at time 1 how unexpected they felt the incident had been, most respondents (74 per cent) felt that their experience was 'unusual but one of the risks of the job'. Another 15 per cent felt that it was 'part of the job, happens all the time', while the remaining 11 per cent felt that it was 'totally unexpected'.

There was some variation in response according to type of incident. Notably, victims of physical assaults were more likely to perceive their experience as 'totally unexpected in this job'; 52 per cent of this group responded to this item in this way, compared to only ten per cent of respondents overall.

Table 4.2: Perception of the event by incident type

	Dog attack		Accidents, falls and RTA		Physical assaults		Robbery/ attempted robbery		Armed robberies, hostages and ram raids		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Part of the job, happens all the time	23	22.8	1	3.7	0	0.0	13	16.9	19	15.1	56	15.5
Unusual but one of the risks of the job	75	74.3	18	66.7	15	48.4	62	80.5	99	78.6	269	74.3
Totally unexpected in this job	3	3.0	8	29.6	16	51.6	2	2.6	8	6.3	37	10.2
Total	*101*	*100*	*27*	*100*	*31*	*100*	*77*	*100*	*126*	*100*	*362*	*100*

Missing cases = ten, (2.5 per cent)

Source: IES survey

Respondents were also asked to rate the incident according to its effect. Most reported that the incident had been 'very upsetting' (41 per cent) or 'a bit upsetting' (35 per cent), while a small but significant proportion (18 per cent) felt that it had been 'totally devastating'. Physical assaults feature as particularly distressing.

Table 4.3: Impact of the incident by incident type

	Dog attack		Accidents, falls and RTA		Physical assaults		Robbery/ attempted robbery		Armed robberies, hostages and ram raids		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
No big deal	14	13.7	3	10.7	0	0.0	3	3.7	1	0.7	21	5.3
A bit upsetting	68	66.7	9	32.1	7	21.2	22	26.8	32	23.0	140	35.4
Very upsetting	19	18.6	8	28.6	20	60.6	36	43.9	75	54.0	163	41.3
Totally devastating	1	1.0	8	28.6	6	18.2	21	25.6	31	22.3	71	18
Total	*102*	*100*	*28*	*100*	*33*	*100*	*82*	*100*	*139*	*100*	*395*	*100*

Missing cases = 4

Source: IES survey

4.2 Level of support offered

This section considers the organisation's response to the incident as reported by respondents.

The model of intervention offered by RMG involves three levels of support to employees and franchisees following an incident. These are:

- defusing/crisis management
- SPoT meeting
- further support offered by OH.

In this section data on each of these forms of support is looked at in turn, considering who was offered and received that type of support. More specifically the response to the incident by the organisation on the day as reported at time 1, support from the organisation in the form of SPoT, which may have taken place by time 2, further support offered by OH during the year after the incident are all reviewed. In addition, respondent reports of an important form of support which is not delivered by the organisation, that of social support, are considered. Social support can have a mediating or moderating affect on the other variables.

4.2.1 Defusing or crisis management

Defusing/crisis management is the first level of organisational support available to workers following an incident. It encompasses dealing with the immediate practicalities of any incident, such as taking over if the individual is unable to continue working, ensuring that they are not returning to an empty home, assisting in reporting the incident, securing premises, organising repairs and restocks, dealing with police and security services. It is difficult to define clearly the components of crisis management as it can involve such a wide range of activities. Indicators that some form of crisis management has occurred are inevitably wide ranging. However, the figures below suggest that it is possible that some workers may not experience any initial activities on the day.

Looking at respondents at time 1 of the survey, we know that 37 per cent of survey respondents recall a network manager and/or supervisor attending the incident, indicating some crisis management may have been offered by the organisation in this proportion of incidents. In CHD and PON, incidents were more likely to be attended by a Network Manager. CHD incidents were also more likely than service delivery incidents to be attended by a supervisor. The police were actually the most common visitors in the initial period following an incident, in attending 60 per cent of incidents.

Table 4.4: RMG attendance of the incident by business area

	CHD		Service delivery		PON		Total	
	N	%	N	%	N	%	N	%
Network Manager attended the incident	9	37.5	13	8.1	89	43.0	111	28.3
Supervisor attended the incident	11	45.8	16	9.9	14	6.8	41	10.5
Royal Mail security staff attended	2	8.3	3	1.9	9	4.3	14	3.6
Total	*24*	—	*161*	—	*207*	—	*392*	—

Missing cases = 7

Source: IES survey

Sixty-one per cent of respondents were required to give a witness statement to the police or the Royal Mail investigator on the day of the incident. Of those who gave a statement, 24 per cent were accompanied to the police station by a member of RMG staff and a further two per cent declined an offer to be accompanied. This was not consistent across categories of incident; victims of 'dog attacks' and 'accidents, falls and RTAs' were more likely to be accompanied, although this was not a statistically significant difference, while those working in PON were least likely to have such assistance (this is not surprising given the proportion of franchise holders in PON).

Managers asked employees whether someone would be at home in 18 per cent of cases. The likelihood of this differed significantly according to incident type. Results show that managers were considerably more likely to ask this question following a 'physical assault', in which this occurred in 39 per cent of cases. Overall managers asked whether someone would be at home in 18 per cent of cases, although this was significantly more likely to occur for CHD employees where it was reported in 39 per cent of cases.

Table 4.5: Defusing activities by business area

	CHD		Service delivery		PON		Total	
	N	%	N	%	N	%	N	%
Assistance offered with police/ security statement	12	52.1	21	44.7	25	15.9	59	15.9
Total	*23*	—	*47*	—	*157*	—	*227*	—
Manager asked whether had support at home that day	9	39.1	25	17.4	19	16.0	53	18.5
Total	*23*	—	*144*	—	*119*	—	*286*	—

Missing cases = 25

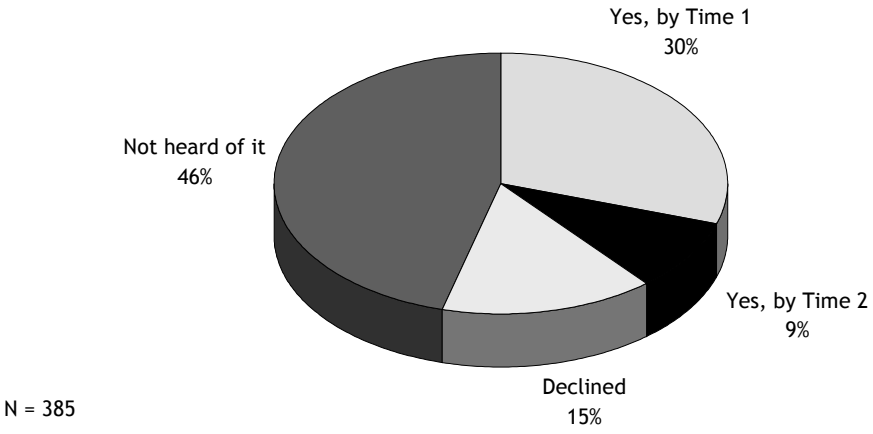
Source: IES survey

4.2.2 Support post trauma (SPoT) meetings

SPoT, previously known as manager debriefs or trauma debriefs, are the second level of support offered to individuals involved in traumatic incidents in RMG's trauma care programme. These support meetings are delivered by RMG managers trained by OH staff. Such meetings can take place in the days and weeks following the incident and as such, may not have happened when survey respondents return a questionnaire at time 1. Therefore respondents were also asked at time 2 whether they had attended such a meeting.

Here the numbers of respondents who recall having such a meeting are reported. Figure 4.2 shows the frequencies of respondents who had attended a SPoT meeting at different stages of the survey. Thirty per cent of respondents had been to a SPoT meeting by time 1. This rose to 39 per cent by time 2. Forty-six per cent of respondents had never heard of this form of support.

Figure 4.2: Awareness of and participation in SPoT meetings



Note: Missing cases = 73, (15.9 per cent)
Source: IES survey

In the early weeks (ie by time 1), 32 per cent of respondents had participated in or were intending to participate in a SPoT meeting. This varied considerably across different parts of the business. CHD employees were much more likely to have been offered and to have taken part in a SPoT meeting, while a considerable proportion (61 per cent) of respondents working in service delivery reported they had never heard about this type of meeting.

Of the sample who had attended a SPoT meeting, 72 per cent reported that they were told about normal reactions and coping mechanisms that can follow a traumatic incident. This was significantly less likely to be the case if they worked in service delivery, where only 48 per cent of employees reported receiving this information. Eighty-one per cent of respondents reported that they had been told where they could obtain further support if they felt it would be helpful. This figure was significantly

lower for service delivery respondents (62 per cent) relative to those working in CHD or PON (81 and 91 per cent respectively).

Table 4.6: Cross tabulation of SPoT attendance by business area (time 1)

	CHD		Service delivery		PON		Total	
	N	%	N	%	N	%	N	%
Yes, already taken part	15	62.5	37	23.3	62	31.2	114	29.8
I am going to take part	1	4.2	3	1.9	4	2.0	8	2.1
I declined the offer	3	12.5	4	2.5	33	16.6	40	10.5
Mentioned but heard no more	1	4.2	3	1.9	7	3.5	11	2.9
Never mentioned but know I can request it	0	0	15	9.4	12	6.0	27	7.1
Never heard of it	4	16.7	97	61.0	81	40.7	182	47.6
Total	*24*		*159*		*199*		*382*	

Missing case = 7

Source: IES survey

4.2.3 Further professional support

Further support was delivered by OH to a much smaller number of respondents whose need for such support had either been identified during a SPoT meeting, by managers or via self-referral. The researchers had two sources of information on participation in more intensive support mechanisms, self-reports from respondents at time 2 of the survey and administrative data from OH available for both respondents and non-respondents.

At time 1, 25 per cent of respondents said they had been offered an appointment with OH (more commonly known to workers as 'employee health services' at the time of the survey). Of those who had been offered an appointment 26 per cent had accepted, or approximately six per cent of the total sample. This scale of participation is confirmed by OH records, which indicate that three to four per cent of survey respondents[7] had received some additional counselling from OH in the year since experiencing their incident.

This type of support appears to be well established in CHD where both availability and take-up of professional support are high. In contrast, service delivery workers are much less likely to be offered such an appointment. This may reflect greater variation in severity of incidents within service delivery. PON franchisees are more likely than service delivery workers to be offered such an appointment but are more likely to decline the offer. Whereas around 50 per cent of RMG employees accept the offer of further support, only ten per cent of franchise holders do.

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[1] A similar proportion of non-respondents sought professional counselling; according to OH records.

Participation in professional support mechanisms[8] was also investigated at time 2 of the survey. Interestingly a slightly higher percentage of respondents indicated that they had such further support. Again the likelihood of reporting such support was significantly higher for CHD employees than those in other areas of the business.

Table 4.7: Health professional appointment (self-report), by business area

	CHD		Service delivery		PON		Total	
	N	%	N	%	N	%	N	%
Manager offered an appointment with health professional	16	66.7	20	12.7	58	30.4	94	25.3
Total	*24*	—	*157*	—	*191*	—	*372*	—
Accepted the appointment with health professional	8	61.5	9	42.9	6	10.7	23	25.6
Total	*13*	—	*21*	—	*56*	—	*90*	—

Source: IES survey

4.2.4 Social support

A short measure of social support was designed for the study, consisting of four questions to investigate four commonly included aspects of social support scales: practical, informational, pleasurable and emotional support. More specifically, respondents were asked how often the following types of support were available:

- someone to give practical support (eg help with daily chores)
- someone to confide in or ask for advice
- someone to go out with and do something enjoyable
- someone to show love and affection.

Responses were scored on a five-point scale ranging from 1 – 'none of the time' to 5 – 'all of the time'. At time 1 average ratings showed the lowest levels of support reported for 'someone to give you practical support'.

There was some, but no significant, variation in reported levels of support across different areas of RMG business. There was however significant variation according to incident type, as shown in Table 4.8: those who had experienced 'accidents, falls, and RTAs' reported the highest levels of support, while victims of 'dog attacks' reported the lowest.

[1] Such support was historically known as 'critical incident debriefing' by many workers, though such a name does not accurately reflect the nature of the support, which is more akin to trauma counselling.

Table 4.8: Support available after the incident, by type of incident (time 1)

Type of traumatic incident	Mean	Median	N
Dog attack	3.4	3.875	100
Accidents, falls and RTAs	4.2	5	28
Physical assaults	3.8	4	31
Robbery/attempted robbery	3.8	4.25	74
Armed robberies, hostages and ram raids	3.5	3.75	126
Total	*3.6*	*4*	*359*

Note: Missing cases = 40, (10.0 per cent)

Source: IES survey

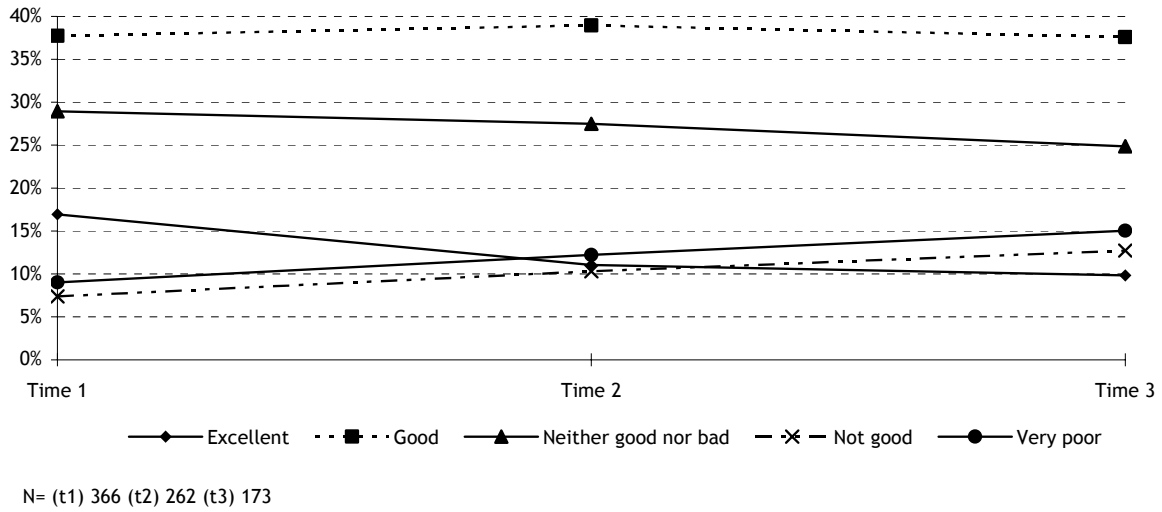
4.3 Satisfaction with organisational response

This section focuses on respondents' satisfaction with the organisational response on the day, their assessment of information received during SPoT meetings and the information and support received in general since the incident.

4.3.1 Attitudes to support received on the day of the incident

Figure 4.3 shows ratings obtained from respondents at times 1, 2, and 3 showing a fairly high degree of satisfaction with the support provided on the day of the incident. Seventeen per cent of respondents at time 1 rated the support on the day as excellent and a further 38 per cent of respondents reported the support as good. The distribution of ratings was roughly consistent across time points. This suggests that perceptions of support received on the day of the incident endure.

Figure 4.3: Ratings of support received on the day of the incident



N= (t1) 366 (t2) 262 (t3) 173

Notes: Missing cases = [t1] 33, (8.3 per cent), [t2] 8, (3.0 per cent), [t3] 7, (3.9 per cent)

Source: IES survey

Employee ratings of the support offered to them by their organisation on the day of the incident did not vary significantly across the different business areas of RMG, although there was a trend towards higher scores for PON.

4.3.2 Satisfaction with the information provided in SPoT meetings

One hundred and sixteen respondents had taken part in a SPoT meeting by time 1. These participants were asked to rate the meeting on a number of factors. When asked about the amount of information given in the meeting, 87 per cent considered that this was just right, ten per cent felt more information could have been provided and only three per cent felt too much information had been provided.

When asked about the quality of information provided, 64 per cent of respondents felt the information received during the session was of good quality, and 12 per cent considered the information to be of excellent quality. A further 21 per cent felt the quality was average and only three per cent rated the quality as poor. A smaller proportion of respondents working in service delivery reported that the quality was good (49 per cent), compared to those in CHD (81 per cent) and PON (71 per cent). While CHD seemed most satisfied with the quality of information received, it was not possible to test whether these differences were statistically significant owing to small cell sizes.

Overall respondents indicated a very high degree of satisfaction with the amount and quality of information provided.

4.3.3 Information and support since the incident

Respondents were also asked to what degree they agreed (on a five point scale) with a set of statements about the support and information they had received from the organisation more generally since the incident. Two general scales were compiled, one for information and one for support, each containing four items as outlined in Tables 4.9 and 4.10 below. A score of five indicates the respondent agreed strongly with the statement and a score of one indicates that the respondents did not agree. There was a high degree of agreement with the statement that the information provided by the organisation since the incident helped respondents realise that the symptoms they were experiencing were normal reactions.

Table 4.9: Information from organisation since the incident, reported at time 1

	Mean	Std Dev	N
I realised the symptoms that I was experiencing were normal in circumstances	3.8	1.02	295
I had a better idea of what to expect in the coming weeks	3.0	1.22	261
I knew where to obtain information should I need it	3.2	1.315	314
I had a better idea of where in the company I could go for support	3.1	1.30	304

Source: IES survey

Table 4.10: Support from the organisation since the incident, reported at time 1

	Mean	Std Dev	N
I felt the company cared about my well-being	3.1	1.26	351
The company enabled me to get 'back to normal' quicker	2.7	1.25	306
I felt confident about returning to my role/carrying out my normal duties	2.6	1.25	282
I felt confident about going to work generally (any job)	2.8	1.29	305

Source: IES survey

The most notable aspect of this set of questions is that respondents' assessment of the support and information in general provided by the organisation appears to remain fairly stable over time. When responses from the subset of respondents who replied at all three time points are considered, there is very little change from time 1 to time 3 in respondents' assessment of either the support or information provided by the organisation since the incident.

There was some variation in the assessment of information provided by the organisation by business area, with those working in service delivery giving a lower average score for the information provided by the organisation. This pattern was observable at all three time points but was only significant at time 1 and time 2. However, those working in service delivery seem more positive about the support from the company than those working in the other business areas, though this difference was not statistically significant.

Ratings of the support received from RMG were also collected at time 1 using a five point scale from excellent to very poor (Table 4.11). These show that there is some variation between staff in different types of jobs, with PON staff more likely to rate the support as excellent or good.

Table 4.11: Ratings of support across Royal Mail business areas at time 1

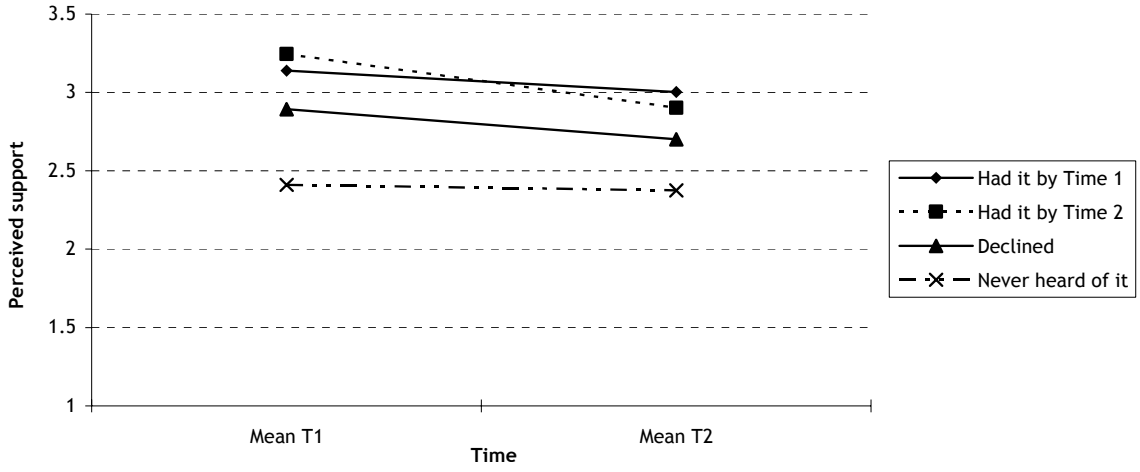
	CHD		Service delivery		PON		Total	
	N	%	N	%	N	%	N	%
Excellent	4	19.0	27	17.5	31	16.6	62	17.1
Good	7	33.3	49	31.8	81	43.3	137	37.8
Neither good nor bad	8	38.1	51	33.1	45	24.1	104	28.7
Not good	1	4.8	8	5.2	17	9.1	26	7.2
Very poor	1	4.8	19	12.3	13	7.0	33	9.1
Total	*21*	*100*	*154*	*100*	*187*	*100*	*362*	*100*

Source: IES survey

4.4 Support by intervention group

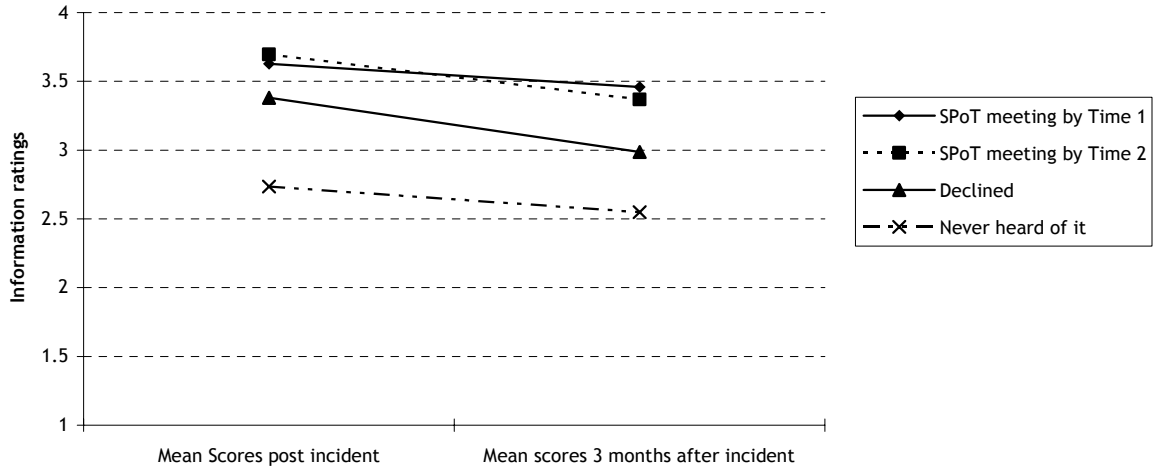
Analyses were conducted to examine reactions to support on the basis of whether or not employees had attended a SPoT meeting. There were significant differences between the two groups, with those who attended a SPoT meeting more likely to feel reassured about the symptoms they were experiencing, know where to obtain information should they need it and know where in the organisation they could go for further support. Also, those who attended SPoT meetings were significantly more likely to feel that RMG was concerned about their well-being and that the support they received enabled them to 'get back to normal' quicker. For some, there were also improvements in confidence in returning to work.

Figure 4.4: Perceptions of support by attendance at SPoT meeting



Source: IES survey

Figure 4.5: Information ratings by intervention status



Source: IES survey

Key points

- The most commonly reported features of incidents were counter snatch or raid, weapons, dogs and physical assaults.
- The vast majority of respondents directly experienced the incident rather than witnessed it and two-thirds were working remotely at the time of the incident.
- Physical assaults in particular were perceived to be unexpected and extremely distressing events for respondents.
- Almost one-third of respondents had participated in the SPoT protocol, but this varied considerably across different parts of the business. CHD employees were more likely to have been offered SPoT and to have participated while a considerable proportion of respondents working in service delivery (61 per cent) reported they had never heard about this type of meeting. (This reflects the implementation of SPoT meetings in those high risk parts of RMG businesses such as PON/CHD.)
- Satisfaction with levels of support offered by the organisation show a pattern of less satisfaction among service delivery workers compared with the other two groups. It is possible that this difference is related to the fact that such workers are less likely to expect to experience incidents (compared with the higher risk occupations in CHD and PON) which is compounded by the fact that SPoT in this area of the business is less well established.
- Employees attending SPoT meetings reported significantly higher scores than others on three important aspects of post trauma management:
  1. reassurance that the symptoms they might be experiencing were normal
  2. knowledge about sources of further information about traumatic reactions
  3. knowledge about where in the organisation to access further support.
- Those who attended SPoT meetings were also far more positive in their views of RMG and the role of support in enabling them to get back to normal, in some cases this extended to greater confidence about returning to work.

5 Outcomes

5.1 Introduction

This chapter explores the relationships between symptom levels, types of support and absence. First, the psychological health of the sample is described, as measured by the IES-R, recovery rates across the sample are discussed and differences based on intervention identified. The chapter then considers results for the other main outcome measures: physical and emotional functioning, sickness absence and contract status. The evidence for more complex relationships between symptoms, support and absence is examined and presents evidence for the link between support and reduced absence. Finally, the chapter explores the value of the trauma screening questionnaire (TSQ) as a predictor of subsequent trauma symptom levels.

5.2 The impact of traumatic events

The IES-R is a widely used and well validated measure of trauma symptoms. The revised version of the scale has three sub-scales which measure symptom levels on the three main clusters of trauma symptoms – avoidance, intrusion and hyper-arousal. The scale's brevity (22 items) and ease of completion makes it suitable for use in questionnaire surveys.

5.2.1 IES-R and IES-R sub-scale results

Reliability was tested for the scale and three subscales within this sample. The overall IES-R scale demonstrated very high internal reliability in this sample at all time points (Cronbach's alpha t1= .97). Internal reliabilities were equally high for the three subscales with this sample at all time points (Cronbach's alphas: avoidance subscale =.90; intrusion subscale =.94; and hyperarousal subscale =.89 [all for time1]).

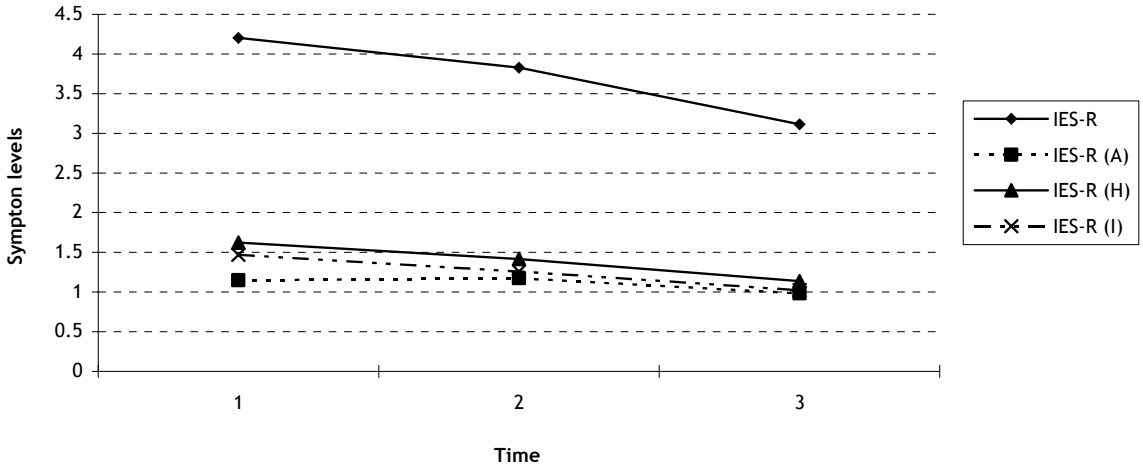
5.2.2 Respondents' trauma symptom levels over time

Because of the non-normal distribution of IES-R scores, non-parametric tests are used in the initial analyses. All results in this section refer to non-parametric analyses unless otherwise stated.

As would be expected, symptom levels across the sample dropped during the course of the research. Respondents' overall IES-R scores indicated a significant drop in symptom levels from immediately post trauma to three months post trauma and again at 13 months post trauma.

For each of the subscales a similar pattern of symptom level was observed. For both the intrusion subscale and the hyperarousal subscale the drops in symptom levels from immediately post trauma to three months post trauma and again from three to 13 months post trauma were significant. However, the avoidance subscale scores, while decreasing over time, did not show significant differences at the three time points (Figure 5.1).

Figure 5.1: Trauma symptom levels over time



Source: IES survey

5.2.3 Symptom levels by business area and type of incident

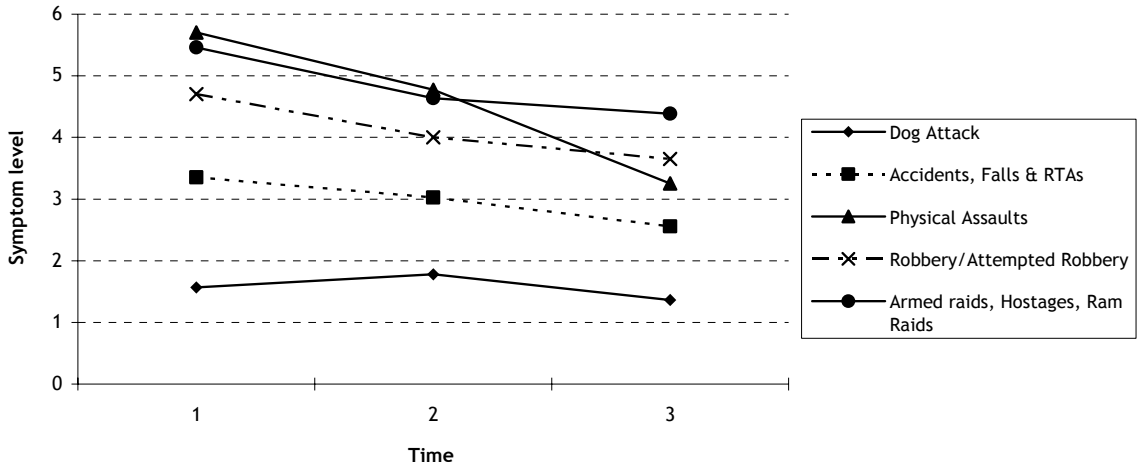
Business area

When analysed by business area, symptom levels on the overall IES-R scale and on each of the three subscales showed significant differences. Respondents working in CHD and PON consistently reported higher symptom levels compared with those in service delivery. These differences become less marked over time.

Type of incident

Scores on the overall IES-R scale and for each of the three subscales were significantly associated with incident type. Respondents who experienced physical assaults and armed robberies, hostage taking situations and ram raids reported significantly higher levels of symptoms than did victims of robbery or attempted robbery, followed by those experiencing accidents, falls and RTAs, then dog attacks. Over time the differences by incident type became less marked as reported symptoms dropped (Figure 5.2).

Figure 5.2: Symptom level by type of incident



Source: IES survey

5.2.4 Symptom level by intervention and support

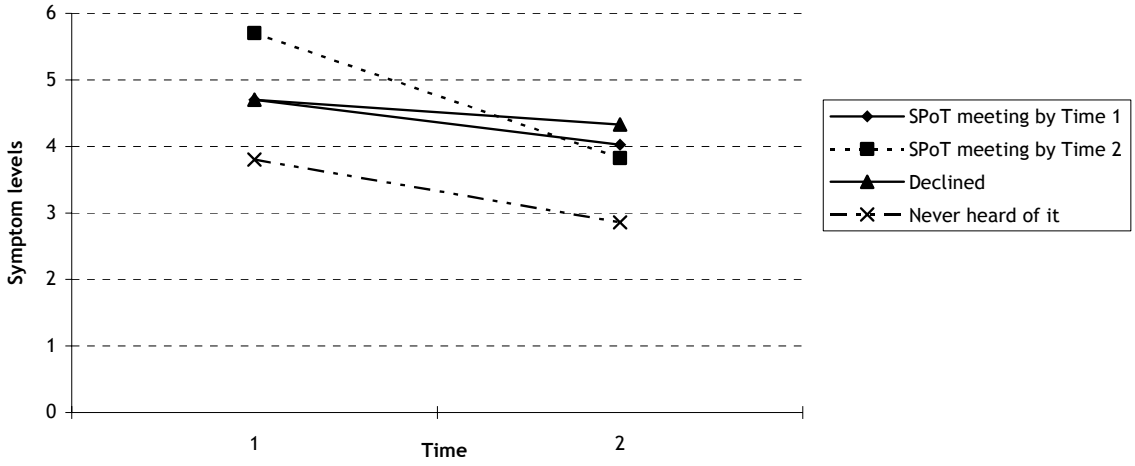
IES-R scores by intervention

IES-R scores were analysed by whether or not respondents had attended a SPoT meeting. No significant differences were found between intervention and non-intervention groups on IES-R overall scores or any of the subscale scores at 13 month follow-up. Recovery rates on the overall measure and subscales did not differ significantly by intervention status, with recovery rates for both groups showing significant health gains at each time point.

Overall this indicates there is no evidence that there are any adverse effects of attending a SPoT meeting with regard to either rate of recovery or overall symptom levels in the longer term.

There is some evidence that timing of the SPoT meeting is associated with significant differences in IES-R scores, immediately post incident and at the three month stage. Highest symptom levels at time1 are found in those who have not yet attended a SPoT meeting. By time 2 (and after attending a SPoT meeting) this group had the lowest symptoms levels of the three groups offered intervention (see Figure 5.3).

Figure 5.3: Symptom levels by intervention over time



Source: IES survey

5.3 Sickness absence of employees

Absence data for the 12 month period post trauma was collected for all RMG employees (but not franchise holders) identified as eligible for inclusion in the study. Absence data was measured in total number of days absent and number of episodes of absence recorded.

5.3.1 Patterns of absence by business and incident type

There were significant differences in both measures of absence level when analysed on the basis of business, with respondents in CHD having significantly higher absence levels than those in service delivery.

Significant differences were also identified on the basis of type of incident experienced. As might be expected, incidents associated with higher levels of symptoms were also associated with higher absence levels. Both physical assaults and armed robbery accounted for higher numbers of episodes of absence. Only experience of armed robbery was associated with a significantly higher number of total days' absence.

5.3.2 Absence by intervention type

Absence patterns were then analysed on the basis of the level of post trauma support. With regard to those receiving trauma counselling in the year following the incident, absence followed the expected patterns and significantly higher levels of absence (both days and episodes) are found for this group.

There were also significant differences on both measures of absence when analysed by attendance at a SPoT meeting (although the differences were more pronounced for number of times absent). This initial analysis included an element of the timing of the

SPoT intervention. Significantly lower rates of absence were found among those respondents who had never heard of SPoT or had attended a SPoT meeting by time 1. Significantly higher absence levels were found among those who declined a SPoT meeting or who attended a SPoT meeting by time 2. These relationships are explored further in Section 5.4.

5.3.3 Absence and perceptions of support

Analyses were undertaken to examine the association between absence and two scales assessing: perceived organisational support since the incident, and perceptions of the availability and quality of information since the incident.

Perceived organisational support at three months post incident was significantly negatively correlated with number of times absent (r = -.23, p < .05) and with number of working days absent (r = -.30, p < .01). No other relationships were significant.

In other words, those who felt more positive about the organisational support they received in the three months following the traumatic incident also had significantly lower absence levels over the 12 month period post trauma.

5.4 Absence, symptoms and support

The findings on perceptions of support, intervention status and objective absence data presented an interesting avenue for further analysis. It was clear from the data that there were associations between the three measures. However, the nature of the linkages required further exploration.

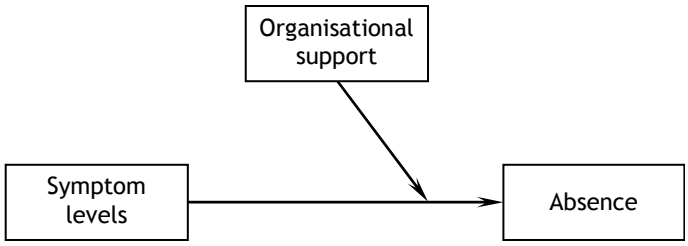
Based on theory and previous research evidence, possible models of the relationship were developed and tested with this dataset.

5.4.1 Support as a moderator of absence

It was clear from earlier results that type of intervention was strongly related both to perceived levels of support and to absence. Initially it was theorised that type of intervention could have a moderating role in determining subsequent absence levels (ie that the relationship between symptoms and absence would vary dependent on the type of intervention received) as represented in Figure 5.4 below.

No support could be found for this in the data, with no evidence that type of support affected the symptoms/absence relationship.

Figure 5.4: Support as a moderator of absence



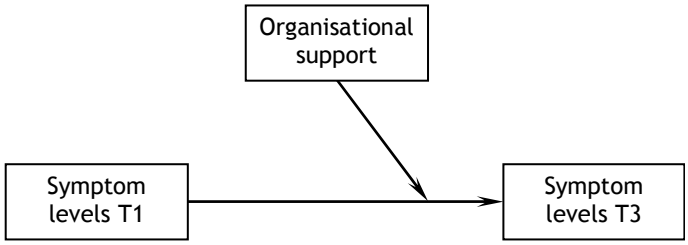
Source: IES

5.4.2 Support as a moderator of symptom levels over time

The next model proposed that type of support could have a moderating effect on symptom levels over time (ie that the observed pattern of symptom levels over time would vary dependent on the type of intervention received).

There was no evidence for the direct effects of symptoms on absence being moderated by level of intervention (Figure 5.5).

Figure 5.5: Support as a moderator of symptoms over time



Source: IES

5.4.3 Perceived support, subsequent symptoms and absence

As neither of the proposed models offered a viable interpretation of the data, attention turned to the specific processes within RMG and in particular, to the expected impact at each stage of the support process.

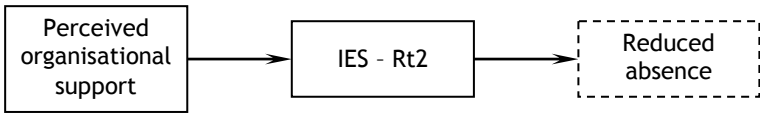
One strong and consistent finding in the earlier analyses had been the importance of perceived organisational support. The perceived support scale included items such as:

'I felt the company cared about my well-being'

'[support] enabled me to "get back to normal" quicker'

It was theorised that perceptions of support, rather than specific interventions, would be more important in determining how confident people felt about returning to work. A model was proposed that looked at the role of perceived support in determining absence, as represented in Figure 5.6.

Figure 5.6: Support and absence, mediated by symptoms



Source: IES

Path analysis was conducted using the structural equation modelling (SEM) package LISREL to explore the utility of this model in explaining relationships in the data. SEM is a statistical technique using data to test models. It is particularly helpful in interpreting data where complex inter-relationships exist between several variables as with this dataset. It does not establish causality, but does confirm whether or not the data are consistent with a causal model (or interpretation).

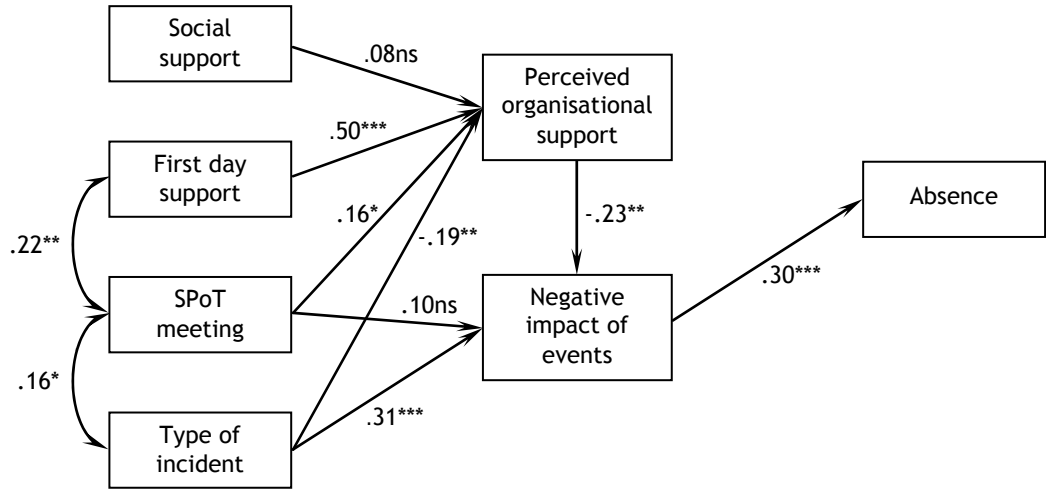
Overall, SEM results for this model found that perceived support at post incident was associated with lower psychological effects three months later and with lower absence 12 months later as predicted. However, the picture that emerged was complex and consistent with two different processes happening at once.

Figure 5.7 presents the pattern of relationships in the data underpinning this model, where:

- **Social support** refers to non-work specific support reported by the individual.
- **First-day support** refers to the individual's perception of the immediate help they received from the organisation.
- **SPoT** refers to the manager support protocol.
- **Type of incident** refers to whether the incident was an accident or the deliberate act of another person.
- **Organisational support** refers to the individual's perception of the support received from the organisation overall since the incident.
- **Negative impact** refers to symptom levels at three months post incident.
- **Absence** refers to days absent over the 12 months post incident.

The results are consistent with the proposed model which suggests that, overall, perceptions of support from the organisation influence symptom levels at three months post trauma and through that, absence levels 12 months post trauma. However, the results also indicate a complex set of relationships with the SPoT meeting having a dual impact both on perceived support and on symptom levels.

Figure 5.7: Types of support and absence, mediated by symptom levels



*p<.05; **p<.01; ***p<.001

Source: IES survey

In this model two clear pathways emerge.

The first pathway links higher levels of support with absence reduction via reduced symptoms. High ratings of the support received on the day of the incident and attending a SPoT meeting are both significantly associated with high perceived organisational support. Another factor important in determining overall levels of perceived organisational support is the type of incident (ie respondents who experience an incident which is accidental are likely to have a more positive perception of the support they receive from the organisation than those who experience an incident perpetrated by another person).

Perceived organisational support is, in turn, strongly associated with lower symptom levels three months post trauma (ie those who rate the support they have received highly are also more likely to have lower symptoms).Lower symptom levels are associated with lower absence.

The second pathway identifies the factors directly associated with high symptom levels three months post trauma and consequently with higher absence. There is a strong positive relationship between incident type and symptom levels at three months, with respondents who have experienced an accident reporting lower symptoms at three months than those who have experienced some form of assault. There is also slight evidence that attendance at a SPoT meeting is associated with slightly higher symptom levels and absence in this data.

The dual role of the SPoT meeting in this model is of particular interest. The results are consistent with the idea that structured management support post trauma enhances feelings of being supported and cared for by the organisation through emotional support and raised self confidence. This in turn impacts on perceived support, lowering symptoms and reducing absence post trauma. However, there is

also a tendency in this data for contact about the incident to increase the negative impact of the incident.

In this sample, the benefits of attending a SPoT meeting outweigh any negatives. However, the possibility of these dual processes at work does raise important questions about which aspects of support could be associated with symptom reduction and which with increased symptoms.

5.5 What constitutes 'good' support?

Within the model presented in the previous section, the single biggest determinant of perceived organisational support is a respondent's rating of the support they received on the day of the incident. The other factor associated with enhanced support is attendance at a SPoT meeting. Both of these are discussed in turn.

5.5.1 Support on the day of the incident

As well as being asked what they thought about support on the day of the incident, respondents were also asked a series of detailed questions about who attended on the day of the incident and the type of support they offered.

The clear finding is that an empathic approach from the line manager (eg displaying concern, checking the respondent was not returning alone to an empty home) was most strongly correlated with overall ratings of support on the day ($r=.29$; $p<0.01$).

A second factor correlated with ratings of support on the day was that of practical support (eg providing help with a witness statement, authorising them to leave the shift early or close the post office for the rest of the day).

These findings are strongly reinforced by qualitative data from the interviews, where the immediacy of the support, an empathic and practical approach are all identified as important aspects of 'what good support feels like'. The key elements to a good organisational response that interviewees mentioned were:

- immediacy of response from manager
- a personal touch
- practical help, being directive
- follow-up in the days and indeed weeks following an incident.

Interestingly those who felt that they had not received a good response identified these same elements as the ones that could have made the response better.

Immediacy of response

Interviewees placed great importance on the immediacy of the response from the organisation and their manager in particular, as the following quotations illustrate:

> *'From the line manager, her name is X, and she's been absolutely superb. Any incident and she is here, sometimes as soon as the police are here, and she stays with us. And follows up on it as well, makes sure you are okay, will phone you at night at home to check you are okay, she's very good.'*

> *'He just made us feel comfortable, asked if I was okay, explained what we could do, lock up and go home, relax, you know, just gave me some guidance because I was responsible in the shop, you have to look after everything and for someone to come in and give you some support straight away is a big help. You don't go through this every day of the week do you, and for someone to be there straight away is what's needed.'*

A personal touch

Interviewees also emphasised a personal, non-formulaic approach was important. Interviewees always preferred telephone calls or visits over cards or letters. While they appreciated a prompt personal visit, they understood that managers may not be able to attend in person and were generally satisfied with a prompt telephone call. Flowers and cards were only appreciated if they were delivered by the manager, but were viewed negatively if they were sent instead of a telephone call or visit. Form letters, whether received from RMG, the union/federation or victim support, were not found to be supportive or informative.

> *'The first time a got the letter, I thought "oh that's nice", then after the second incident another one came through with all the same wording, well then I knew it was a form letter that some administrator prints out, then the third one – well I have a file for them now.'*

Practical help

Post incident, it is primarily practical help that is most valued.

Interviewees appreciated practical help that they received from line managers. In service delivery, interviewees mentioned several specific line manager behaviours:

- sitting down with them and helping with the paperwork (eg filling in an accident report)
- explaining the processes (eg telling them the purpose of each copy of a report etc)
- telling them what they needed to do if taking time-off sick
- driving them home/making sure they were not going to an empty house.

Among the interviewees in PON, examples were given of line managers doing things like ordering new glass for the post office counter that had been smashed or helping

clear up after a raid. Others mentioned that they would have like more practical directive support from their line managers.

> *'I feel that it's all right coming back into work the next day but it would help an awful lot if someone would come in and work with you for a few days. You know, like a trainer to come and take some of the pressure off you because you are straight back at the counter, straight back on, do you know what I mean, straight back into your busy day and for an extra pair of hands there, someone responsible who knows what they're doing who can take charge just for a few days while you get sorted because you have a lot of things to do, just to even say have a couple of days off, go home and sit down and relax. Get your family sorted, get yourself on track.'*

> *'I think at least somebody that could take over if you couldn't make it. Say, yeah, if you're worried, "Can we send someone round?" Even if I have to pay for it, their wage. Send somebody, say "Right, look, go and support him for a day". Say "Look, don't worry about it. Take time off." Because what happens the day you come back, you feel funny and then you might make mistakes. You're worried; thinking about something whilst you're trying to do things. Even if the people have to pay for it, the people who own the business … It's difficult for me to find someone myself to ring and say "Look, come and help"'*

5.5.2 SPoT meetings

As well as collecting data about attendance at SPoT meetings, researchers also collected data from respondents on a series of questions about the content of the meeting and their satisfaction with the meeting.

Meeting content

The single most important element of a SPoT meeting's content (associated with high perceived organisational support) was the provision of information about where to obtain further support within the organisation.

Satisfaction with the SPoT meeting was also important in determining levels of perceived organisational support. Respondents who rated the quality of information given as 'good' or 'excellent' were more likely to report higher levels of perceived organisational support.

Quality of information

Significantly higher ratings of information quality were found among respondents who:

- had the process introduced and explained
- were encouraged to identify symptoms they may have been experiencing since the incident
- were told about the normal reactions and coping mechanisms that often follow a traumatic incident.

Overall, these data indicate several important factors which are associated with enhanced perceived organisational support, reduced symptom levels and subsequently reduced absence. Both support on the day of the incident and attendance at a SPoT meeting are important in determining perceived organisational support.

5.6 Physical and emotional functioning scales

Two short measures were developed by the research team to try and assess the extent to which traumatic experiences affected day to day functioning. The aim was to understand, in a practical sense, the impact that different levels of trauma symptoms had on an individual's ability to carry on with their normal day to day activities.

5.6.1 Description of scales

These two measures were designed to assess the extent to which respondents perceive their normal day to day activities to have been limited by their physical or emotional health.

Both scales consisted of four items and asked respondents to indicate the number of days during the previous week on which day to day activities have been limited by emotional or physical symptoms resulting from the traumatic experience.

Both scales proved to have high internal reliability with this sample (Cronbach's alphas = .95 [physical functioning] and .94 [emotional functioning]).

5.6.2 Validation with general health questionnaire

The 28 item version of the general health questionnaire (GHQ-28) is a well established and validated measure of psychological well-being (McDowell and Newell, 1996). It was designed for use in the general population to screen for possible psychiatric disorder. The emphasis is on self assessed changes in condition, not in absolute levels of a problem.

The concurrent validity of the emotional functioning and physical functioning scales was explored by examining their relationship at three months post trauma with the GHQ-28. Generally, correlations with GHQ-28 and its subscales suggested reasonable concurrent validity. Limited emotional functioning showed strong correlations with higher scores on the anxiety and insomnia subscale of GHQ-28 ($r = .42$, $p < .05$) and the severe depression subscale ($r = .48$, $p < .05$).

A statistical test of significance is the usual method of reporting whether a correlation result shows a true relationship between two variables. However, significance is related to sample size and any correlation not exactly equal to zero can be significant provided the sample is large enough.

The correlation between the emotional functioning scale and the overall GHQ-28 scale was not significant. However, in this case data for both measures at time 2 were only available for a very small sample of 24 people. It is therefore more revealing to examine the effect size (the size of the correlation itself) rather than the significance level. A correlation of 0.1 is regarded as weak, and one of 0.3 is interpreted as moderate (Cohen, 1988). In this case, the correlation between the measure of emotional functioning and GHQ-28 was 0.33, indicative of a moderate relationship between emotional functioning and overall GHQ-28 scores.

Overall the physical and emotional functioning scales were felt to exhibit good concurrent validity.

5.6.3 Emotional and physical limitations by business area and incident type

Non-parametric tests were used to examine whether emotional functioning and physical functioning at time 1, 2, and 3, were associated with the area in which an individual works (CHD, service delivery, PON) or the type of incident they have experienced.

When considered by business area, a significant difference was found in emotional functioning. Respondents in CHD reported significantly more impaired levels of functioning than those in service delivery or PON at time 1, with PON respondents reporting least impairment. However, by three months post incident this difference had disappeared and no differences were found at 13 months post incident. This suggests that CHD respondents have a much stronger immediate post incident reaction, which may in part be because of the nature of incidents in CHD.

Turning to incident type, we found significant differences for emotional functioning at each time point. Poor levels of emotional functioning are more associated with experience of physical assault, armed robberies and hostage taking situations and accidents/falls/RTAs. At each of the time points, there is some suggestion that levels of emotional limitation may remain higher for longer in individuals who have experienced armed raids and hostage taking situations, while it declines for those who have experienced physical assault or accidents/falls/RTAs.

5.6.4 Physical and emotional functioning by intervention type

Differences in emotional or physical functioning were examined according to the respondent's intervention status. There were no significant differences in physical or emotional functioning levels by intervention status.

5.7 Trauma screening questionnaire

The TSQ was devised by Brewin and his colleagues in 2002 to meet the perceived need for a validated screening instrument for PTSD. Although other trauma screening

scales exist they have not been sufficiently validated (Brewin et al., 2002). The ten item measure of the TSQ was included in this survey. Brewin et al. have demonstrated excellent levels of prediction among crime and disaster victims. In this case we were interested in exploring the utility of the measure in predicting those at risk of suffering high levels of trauma symptoms in an occupational setting.

5.7.1 Background to the scale

The scale consists of ten items describing possible reactions to an event (eg, feeling upset by reminders of the event) and asks respondents to indicate (yes or no) whether they have experienced any of the reactions at least twice in the past week.

The scale demonstrated high internal reliability with our sample (Cronbach's alphas = .90).

5.7.2 TSQ by business area and incident type

Significant differences were found when TSQ scores were analysed by business area with respondents in CHD and PON reporting more reactions to incidents compared with respondents in service delivery.

There were also significant differences in scores on the TSQ by incident type, with respondents who had experienced physical assaults or armed robberies, hostage taking situations and ram raids reporting the highest number of symptoms.

This suggests that it may be possible to identify respondents in CHD and PON and respondents experiencing physical assaults, armed robberies and hostage taking situations, who may also be more likely to experience long-term trauma symptoms.

Intervention status, however, was unrelated to TSQ score and there were no significant differences on TSQ scores between those who reported attending a SPoT meeting by time 1, or by time 2, those who declined a SPoT meeting and those who had never heard of it.

5.7.3 Predictive validity of TSQ

Analysis was conducted to look at the relationship between TSQ scores at time 2 and IES-R scores at time 3 to determine whether the TSQ is predictive of subsequent trauma symptoms levels. TSQ was very strongly correlated with IES-R and all its three subscales (avoidance, intrusions and hyperarousal). Correlation between TSQ at time 2 and the overall IES-R at time 3 was $r = 75$, $p < .001$, indicating excellent predictive qualities in this workforce.

Key points

- Symptom levels in this group were measured post incident, at three months and at 13 months. As would be expected, significant drops in symptom level were found at both three and 13 months. There was some variation in symptom level by business area and type of incident. Over time, these differences became less marked.
- There were no differences in symptom levels between those offered a SPoT meeting or not at 13 month follow up, although some differences were found immediately post incident with lower symptoms among those who had already attended a SPoT meeting. No significant differences were found among those offered the intervention at the three month follow-up.
- There were significant differences in absence levels when analysed by attendance at a SPoT meeting, with lower absence found among those who had either attended a meeting or not been offered SPoT by the time of the first questionnaire. Higher absence was found among those who declined a meeting or had attended one by the three months stage.
- Absence was found to be significantly correlated with perceived organisational support, with those who felt supported immediately post trauma also having lower absence 12 months later.
- The patterns of symptoms and absence in relation to level of perceived support hinted at much more complex relationships within the data. Two simple models were proposed where type of support moderates symptoms over time, or moderates the symptoms-absence link. No evidence was found to support either of these models.
- A more complex model was developed based on RMG procedures and tested using the SEM statistical package LISREL. As predicted, perceived organisational support was found to be linked to both symptom levels and absence levels.
- Support on the day of the incident and attendance at a SPoT meeting were both important constituents of perceived organisational support immediately post trauma. A higher level of perceived organisational support post trauma was shown to be linked to lower symptom levels at the three month follow up, which in turn was related to lower absence at 12 months.
- 'Good' support, ie the factors immediately post trauma that were associated with reduced symptom levels, was found to be made up of an empathic response from the line manager and prompt practical support in dealing with the situation and getting back to normal.
- In relation to the SPoT meetings, the most important aspects of 'good' support were found to be the educational element of meeting, ie information about where to go to obtain further support within the organisation, identification of symptoms individuals might have been experiencing since the incident and information about the normal reactions to trauma and coping mechanisms.
- As part of the research, measures of physical and emotional functioning were developed. These scales measured the extent to which physical or emotional symptoms affected an individual's day to day activities in the previous seven days. The measures were found to have good internal consistency and reasonable concurrent validity with the GHQ-28.

- Physical and emotional functioning were found to vary by business type although these differences diminished over time. Scores on both measures also varied by incident type with some evidence that levels of emotional limitation remained higher for those who experienced an assault of some description as opposed to an accident.
- The TSQ was included in this study to explore its use in an organisational setting in identifying employees who may benefit from further support in the longer term. TSQ was found to be an excellent predictor of symptom levels at 13 months within this population.

6 Conclusions

This research was commissioned with the primary aim of providing evidence about the actions that organisations could take to support staff following a traumatic event that are both safe and effective. The findings clearly indicate that organisational intervention can have a positive impact on symptom levels and subsequent absence. Further, no evidence was found to indicate that trauma management procedures implemented by RMG have negative effects. The combination of approaches used at RMG constitutes a trauma management strategy that is both safe and effective.

The study provided a unique opportunity to explore the effects of an organisation's trauma management activities in a real world setting. RMG has long been committed to providing support to employees post trauma and is a UK leader in developing and implementing trauma management services.

Evidence from three data sources has been used to understand the role of the organisation in helping employees to manage post trauma. In-depth interviews, self report survey data and objective absence data have all been analysed to gain an understanding of the complex inter-relationships between types of support, symptoms and absence.

6.1 RMG trauma management procedures

The research focused on two trauma management procedures at RMG:

- Crisis management aims to ensure that employees are offered appropriate support in dealing with the practicalities of any incident. This could involve taking over if the individual is unable to continue working, or assisting in reporting the incident, securing premises and dealing with police and security services. All RMG managers have guidance about how to act in emergency situations.
- SPoT meetings are voluntary meetings with a specially trained RMG manager. The aim of the meeting is to ensure that appropriate management support to the employee is maintained. The meeting follows a standard structure and provides an

opportunity to talk through the facts of the incident, to provide information to the employee about symptoms they might experience post trauma and to give details of further support services within the organisation. The manager at this meeting can also offer the employee an appointment with the professional counselling service.

Both forms of support are clearly structured and provided a unique opportunity to explore the safety and effectiveness of these organisational responses to trauma.

6.2 Safety of the intervention

A growing body of research, mostly based on RCTs or in other clinical settings (rather than within an organisational context like this research) has established that certain forms of post trauma support (specifically single session interventions often referred to as psychological or critical incident stress debriefing) can have negative consequences (increased symptoms) for some individuals. In particular, it is thought that the emotional re-experiencing of the incident that takes place during debriefing interferes with natural coping mechanisms. The SPoT intervention investigated here, while sharing certain characteristics with debriefing (provision of information about trauma symptoms and further support) was intentionally designed to avoid any **emotional** re-experiencing of the incident (although the facts of the incidents are discussed, see Section 6.1). For this reason it was important to assess the safety of the intervention and establish whether it was a successful mechanism for maintaining appropriate support without negative consequences.

Research findings clearly indicate that there is no difference in 13 month symptom levels or recovery rates among the intervention and non-intervention groups in this study.

The research found no evidence of adverse effects for individuals attending a SPoT meeting. The intervention is a safe mechanism for the provision of further support and information for this population.

6.3 Effectiveness of the intervention

The purpose of the intervention was to transmit information to employees about trauma symptoms and further sources of support. Its effectiveness can be considered in a number of ways:

- Does it improve respondents' knowledge of normal reactions to trauma and how to access further support?
- Does knowledge about normal reactions to trauma and further support impact on the medical outcomes (ie symptom levels)?
- Does it impact on behaviours (eg absence)?

With regard to the first point, the findings from this research are clear: SPoT meetings are a highly successful mechanism for conveying information about normal reactions to trauma, with attendees at SPoT meetings significantly more likely to feel reassured about the symptoms they were experiencing, to know where to obtain information should they need it and to know where in the organisation they could go for further support.

There is no indication that attending a SPoT meeting has a direct impact on symptom levels or absence. The SPoT meeting is, therefore, part of a positive overall intervention, but does not have a significant effect on symptoms or absence when offered in isolation.

The research found significantly higher levels of knowledge about normal reactions to trauma and where to access further support within the organisation among those who had attended a SPoT meeting. These differences were sustained in the longer term. The intervention is an effective mechanism for the delivery of information about symptoms and further support for this population.

6.4 The effects of support on symptoms and absence

The key findings from this research demonstrate that overall perceived organisational support (as opposed to specific interventions) is an important factor in determining symptom levels and subsequent absence. Higher levels of perceived organisational support post trauma are associated with lower psychological effects at three months post trauma and lower absence levels at 12 months post trauma.

6.4.1 Perceived organisational support

Perceived organisational support is a combination of the support an individual receives on the day of the incident, and attendance or not at a SPoT meeting. Positive experiences of support immediately following an incident (particularly practical support) and attending a SPoT meeting combine to produce higher levels of perceived organisational support.

Overall ratings of perceived organisational support are also affected by the type of incident experienced. Incidents which occur as a result of another person's actions (as opposed to accidents) are more likely to be associated with lower overall perceptions of organisational support.

The way in which an organisation responds to a traumatic event can reduce individual symptom levels and subsequent absence

6.4.2 Organisational actions that enhance perceived support

There are a number of specific activities identified by this research that enhance perceived organisational support:

- Support on the day of the incident is the single most important factor in determining perceived organisational support. The organisational actions that enhance perceived support include: immediate responses from managers; an empathetic response; practical support to deal with the incident; and a personal, non-formulaic approach.
- SPoT meetings are also an important constituent of perceived organisational support, specifically: information about where to obtain further support in the organisation; having the process introduced and explained; being encouraged to identify symptoms; and being told about the normal reactions to trauma are all associated with higher perceived organisational support.

The research findings indicate a range of organisational actions which are important in determining levels of perceived organisational support.

6.5 How do these findings fit with existing guidance?

The NICE guidance, developed for health care professionals, has three main elements with regard to patients who have experienced trauma:

- Brief single session interventions that focus on the traumatic incident should **NOT** be routine.
- Care providers should engage in 'watchful waiting'.
- Practical, social and emotional support delivered in an empathic manner is important in promoting recovery from PTSD.

The findings presented here are entirely consistent with existing guidance on responses to trauma management. The crisis management and SPoT interventions developed by RMG are safe and effective mechanisms for delivering support; they do not focus on the traumatic incident in any emotional sense, rather on the simple facts of the incident, ie not re-living but simply identifying what happened.

'Watchful waiting' is arguably harder to provide in a non-health care setting. The SPoT meeting therefore also offers an opportunity for a trained manager to monitor an individual and if appropriate, offer further support via the counselling service.

Where RMG intervention goes beyond the NICE guidelines is in recognising that, if an employee experiences a traumatic event in the course of their job, the organisation can have a crucial role to play in managing the incident.

6.6 Why are organisational responses important?

The results from the current research suggest that the interventions developed at RMG (crisis management and SPoT) combine to enhance individuals' perceptions of organisational support. It is this perceived organisational support, above and beyond

specific interventions which appears to reduce symptom levels and subsequent absence.

Raphael et al. (1995), writing in the BMJ, posed the question of why debriefing was 'so successful as a social movement and believed in as an ideology, given the lack of adequate evidence of its benefits?' One answer they proposed was that debriefing met many needs, including the: 'symbolic needs of workers and management to assist those who suffer and show concern.'

Since 1995, a number of important research studies into debriefing have been published. However, research to date has largely been dominated by medical perspectives and methods in the evaluation of debriefing. Organisational perspectives into managing trauma have received much less attention.

Evaluations of debriefing have quite rightly questioned the impact of debriefing on medical outcomes (symptom levels) and used rigorous methods (RCTs) to establish that debriefing is at best neutral, at worst harmful to individuals. As a 'treatment' to reduce symptoms its use is no longer justified.

6.6.1 Treatment or management?

Arguably the reason that debriefing persists as a organisational response to trauma, despite the established risks for some employees, is precisely because it helps to meet other non-clinical needs within the organisation. In other words the 'treatment' aspect of debriefing (ie symptom reduction) is only one of a number of reasons that organisations debrief. The lack of an alternative to date means that poor treatment practice persists because debriefing contains elements of good management practice.

Rick et al. (1998) found that case study organisations that used debriefing reported a number of non-symptom related benefits (similar to those suggested by Raphael et al., op cit) and suggested that the debriefing process, while questionable on clinical grounds, was highly valued in terms of a management process from an organisational perspective. Often these 'management' outcomes were reported by the organisations as 'unforeseen' or 'additional' benefits of setting up a debriefing programme.

6.6.2 What alternatives are there for organisations?

The main area in which debriefing differs from a management process is where the participants are taken through a period of intense re-exposure to the event itself (Rick et al., 1998). It is this reconstruction of the trauma and re-living of the emotional experience that is considered harmful. It has been proposed that some of the elements of a debriefing session which are valued by recipients (eg discussing facts, sharing information about symptoms and further forms of support) could, with some adaptation, contribute to good management of the situation (Rick and Briner, 2000).

This view is further backed by a recent research study (Sijbrandij et al, 2006) which found that 'educational' debriefing (in which the 're-experiencing' element of the debrief was excluded) had no effects on symptom levels, whereas 'emotional' debriefing resulted in increased symptom levels for some participants in the study. The findings from RMG with regard to the SPoT meeting also support this view.

SPoT meetings were found to be an effective means of communicating information to employees about trauma symptoms and sources of support while avoiding emotional re-experiencing of the incident. However, the findings from RMG indicate that SPoT meetings were only part of the overall picture.

The nature of support given immediately post trauma (crisis management) was found to be important in determining overall perceived organisational support. This would indicate that organisations also need to focus on giving immediate practical support to those who experience a traumatic incident at work.

6.7 Future practice

This research was commissioned to provide evidence about safe and effective trauma management practices from an organisational perspective. The findings demonstrate that the approaches developed by RMG provide both an effective and safe mechanism for providing information and support.

Ultimately these findings suggest that the way an individual perceives the support they receive from their organisation can impact on symptom levels and subsequent absence. The advantage of the RMG approach is that it is a relatively simple yet structured approach which can be implemented in many different work settings.

The factors that appear most important in influencing perceived organisational support can be embodied in a simple framework for intervention such as this, adapted from Devilly and Cotton (2003), which also covers the elements of the RMG approach:

1. an up to date, evidence-based organisational trauma management policy
2. access to immediate practical support from the organisation, tailored to individual needs
3. provision of factual information and normalisation of reactions
4. monitoring of staff to identify individuals at risk
5. provision of early access to cognitive based therapies for individuals who report enduring distress.

A framework such as this can provide the basis on which an organisation can develop effective trauma management practices.

6.8 Future research

This study has identified that the way individual employees perceive the support offered by their organisation post trauma could play an important part in their recovery. Some evidence is available from this research about the factors influencing perceived organisational support. Further research to understand these factors better will help organisations to hone their trauma management practices in the future.

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Appendix 1: Questionnaire (Time 1)

Time 1 questionnaire

SUPPORT FOR STAFF FOLLOWING INCIDENTS AND ACCIDENTS AT WORK

Confidential to the Institute for Employment Studies

Please answer the following questions as fully as you are able by ticking the boxes or writing in the spaces provided. We understand that this may be difficult or painful to do but appreciate any and all the information you can give us. It is important that you complete this questionnaire as soon after the incident as possible, ideally within a couple of days. Please return the completed questionnaire to IES in the reply-paid envelope provided.

If you do not wish to take part in the study, please tick this box ☐ and then return the questionnaire in the reply paid envelope. By doing this, you will be informing us that you do not wish to be sent further questionnaires or reminders.

If you have any queries, please contact XXXXXX (Tel: XXXXXX). Thank you for your co-operation.

A: The nature of the incident

This section asks about the recent incident (we will ask about other incidents later). Different management responses are likely to be needed for different types of incidents and contexts and your answers to the following questions will help us to identify what works best in different circumstances.

1. When did this incident occur? (*Please tick one box only)*

Within the past 48 hours	☐ 1	Two to four weeks ago	☐ 4
In the past seven days	☐ 2	Over four weeks ago	☐ 5
Between one and two weeks ago	☐ 3		

2. Did the incident involve any of the following actual or attempted elements? (*Please tick all that apply*)

a) A road traffic accident	☐	h) Witnessing or hearing about physical injury to others	☐
b) Another type of accident (including trips and falls)	☐	i) A death	☐
c) Verbal assault	☐	j) Burglary to the premises (*ie* when you were not present)	☐
d) Physical assault	☐	k) A countersnatch or raid on premises (*ie* when you were present)	☐
e) A dog attack	☐	l) Theft (to your person, of mail, to van *etc.*)	☐
f) A weapon	☐	m) Hostage	☐
g) Physical injury to yourself	☐	n) Other (*please specify*)	☐

3. Did you? *(Please tick one box only)*

Directly experience the incident (this includes witnessing the event)	☐ 1	***Go to Q4***
Come across the scene after it had happened	☐ 2	***Go to Q4***
Hear about it from someone else ***Go to Q5***	☐ 3	

4. Were you working remotely (*ie* on your own) at the time? (*Please tick one box only*)

yes ☐ 1 no ☐ 2 don't know/can't remember ☐ 3

5. Would you say that this type of incident is (*Please tick one box only*):

– part of the job, happens all the time ☐ 1

– unusual but one of the risks of the job ☐ 2

– totally unexpected in this job ☐ 3

6. Would you describe the incident as (*Please tick one box only*):

– no big deal ☐ 1

– a bit upsetting ☐ 2

– very upsetting ☐ 3

– totally devastating ☐ 4

B: Initial response on the day of the incident

Thinking back to the day of the incident . . .

7. Who attended the incident? (*Please tick all that apply*)

Network manager	☐	Supervisor	☐
Ambulance	☐	Fire and Rescue	☐
Police	☐	Royal Mail security staff	☐
Employee Health Services	☐	Don't remember	☐
I didn't know who all the people were	☐	Other (*Please specify*)	☐

.....

8. Were you required to give a witness statement to the police or to a Royal Mail Group investigator? (*Please tick one box only*)

yes, on the day	☐ 1	***Go to Q9***	no	☐ 3	***Go to Q10***
yes, but not on that day	☐ 2	***Go to Q9***	don't know/ can't remember	☐ 4	***Go to Q10***

9. If yes, did a member of staff assist you with this or accompany you to the police or security office? (*Please tick one box only*)

yes	☐ 1	no	☐ 3
offered, but I declined	☐ 2	don't know/ can't remember	☐ 4

10. Did you continue working your shift that day (*ie* the day the incident happened or the day you learned about the incident)? (*Please tick one box only*)

Yes, I continued working that day	☐ 1
No, I left my shift early/closed the premises	☐ 2
No, it was the end of the shift/I was off duty at the time	☐ 3
Other (Please specify)	☐ 4

.....

11. Did your manager (or performance advisor) ask you if there would be someone at home when you returned to your house? (*Please tick one box only*)

yes ☐ 1 no ☐ 2 don't know/can't remember ☐ 3 not applicable ☐ 4

12. Overall, how would you rate the support offered to you by the organisation on the day of the incident?

Excellent	☐ 1
Good	☐ 2
Neither good nor bad	☐ 3
Not good	☐ 4
Very poor	☐ 5
Don't remember	☐ 6

C: Employer contact and support since the incident

This section is about the types of contact and support that you have received from your employer in the last few days (the few days following the incident), and also what impact this support has had.

13. Following incidents such as this one, you may be invited to take part in a formal session lasting about an hour with a nominated manager to talk about what happened – this is called a *Manager (or Trauma) Debrief*. **A Manager Debrief is intended to be beneficial to you and is not intended for security purposes**. Did a manager talk to you about the incident in this way? *(Please tick one box only)*

Yes, I have already taken part in a Manager Debrief	☐ 1	***Go to Q14***
I am going to take part in one (a time and place has been set)	☐ 2	***Go to Q19***
I was asked if I wanted to take part but I declined	☐ 3	***Go to Q19***
It was mentioned but I've heard nothing more	☐ 4	***Go to Q20***
No one has mentioned it since the incident but I know I can request it	☐ 5	***Go to Q20***
I've never heard about Manager Debriefs (before this research)	☐ 6	***Go to Q20***

14. Was this (*Please tick one box only*):

. . . . as a group? ☐ 1 . . . . as an individual? (face to face) ☐ 2 . . . . on the telephone ☐ 3

15. There are a number of different types of debriefing conducted in Royal Mail Group, containing different elements. During the manager debrief: (*Please tick all that apply*)

	Yes	No	Don't know / can't remember
a) Did the manager introduce and explain the debriefing process?	☐	☐	☐
b) Were you required to describe the facts of the incident in detail?	☐	☐	☐
c) Did you have to identify the most traumatic aspect of the event?	☐	☐	☐
d) Were you encouraged to identify symptoms you may have been experiencing since the incident?	☐	☐	☐
e) Were you told about the types of normal reactions and coping mechanisms that often follow a traumatic incident?	☐	☐	☐

16. During the Manager Debrief, were you told where to obtain further support should you require it?

yes ☐ 1 no ☐ 2

17. How do you feel about the amount of information you received during the session. Was it:

. . . . too much ☐ 1 . . . . too little ☐ 2 . . . . just right ☐ 3

18. How do you feel about the quality of the information you received during the session. Was it:

. . . . poor ☐ 1 . . . . average ☐ 2 . . . . good ☐ 3 . . . . excellent ☐ 4

19. How much choice did you have about attending the Manager Debrief? Please tick the option which best describes the degree to which you decided whether or not to attend *(Please tick one box only)*

It was obligatory to attend	☐ 1
It wasn't obligatory, but I was expected to attend	☐ 2
The decision was completely up to me	☐ 3
I was offered a manager debrief but I got the impression that people would prefer if I didn't accept	☐ 4
I had to push to get a Manager Debrief	☐ 5

20. A)Thinking generally about the information you have received from the organisation since the incident, please indicate to what extent you agree with each of the following statements by circling the appropriate number (*Please circle one number for each statement*)

	Do not agree				**Agree strongly**	
a) I realised the symptoms that I was experiencing were normal in the circumstances	1	2	3	4	5	Not Applicable
b) I had a better idea of what to expect in the coming weeks	1	2	3	4	5	Not Applicable
c) I knew where to obtain information should I need it	1	2	3	4	5	Not Applicable
d) I had a better idea of where in the company I could go for support	1	2	3	4	5	Not Applicable

20. B) Thinking generally about the support you have received from the organisation since the incident, please indicate to what extent you agree with each of the following statements by circling the appropriate number (*Please circle one number for each statement*)

	Do not agree				**Agree strongly**	
a) I felt the company cared about my well-being	1	2	3	4	5	Not Applicable
b) I felt more confident about going back to work/being at work	1	2	3	4	5	Not Applicable
c) It enabled me to get 'back to normal' quicker	1	2	3	4	5	Not Applicable
d) I felt confident about returning to my role/ carrying out my normal duties	1	2	3	4	5	Not Applicable

21. Has your manager (or performance advisor) offered you an appointment with the Employee Health Service for further help with the incident?

yes ☐ 1 ***Go to Q22*** no ☐ 2 ***Go to Section D, Q24***

22. Have you accepted the appointment?

yes ☐ 1 ***Go to Q23*** no ☐ 2 ***Go to Section D, Q24***

23. If yes, when is this appointment?

(Please write in date, in the day/month/year format) ____/____/____

D: Your health

This section asks for your views about your own general health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Please answer every question by ticking the appropriate box or circling the appropriate number. If you are unsure about how to answer a question, please give the best answer you can.

24. Before this incident how would you describe your general physical health?

Excellent (fully fit and healthy)	☐ 1
Good (more healthy than most)	☐ 2
Average (as good as anyone else)	☐ 3
Poor (less fit than most people)	☐ 4
Very poor (much less fit and healthy than most people)	☐ 5

25. Before the incident, how would you describe your emotional health?

Excellent (no real worries or concerns)	☐ 1
Good (a few worries but nothing major)	☐ 2
Average (no more or less anxious than anyone else)	☐ 3
Poor (tend to worry more than the people around me)	☐ 4
Very poor (tend to get anxious or depressed much more than most people)	☐ 5

26. How has the incident affected your physical health?

Not at all, (it's the same or better than before the incident)	☐ 1	***Go to Q28***
A little bit, (it's slightly worse than before the incident)	☐ 2	***Go to Q27***
Quite a lot, (it's much worse than before the incident)	☐ 3	***Go to Q27***

27. As a result of the incident, how many days in the last week would you say your **physical** health has limited you from: *(Please circle number of days)*

Going to work as normal	0	1	2	3	4	5	6	7
Meeting up with friends or relatives/socialising	0	1	2	3	4	5	6	7
Day to day activities (*eg* getting the papers or food shopping)	0	1	2	3	4	5	6	7
Doing chores or odd jobs around the house	0	1	2	3	4	5	6	7

28. How has the incident affected your emotional health?

Not at all, (it's the same or better than before the incident)	☐ 1	***Go to Q30***
A little bit, (slightly more worried or anxious than before the incident)	☐ 2	***Go to Q29***
Quite a lot, (much more worried or anxious than before the incident)	☐ 3	***Go to Q29***

29. As a result of the incident, how many days in the last week would you say your **emotional** health has limited you from: *(Please circle number of days)*

Going to work as normal	0	1	2	3	4	5	6	7
Meeting up with friends or relatives/socialising	0	1	2	3	4	5	6	7
Day to day activities (*eg* getting the papers or food shopping)	0	1	2	3	4	5	6	7
Doing chores or odd jobs around the house	0	1	2	3	4	5	6	7

E: The personal impact of the incident

The following difficulties sometimes happen to people following an incident. Please read each item, and then indicate how distressing each difficulty has been for you.

30. How much were you distressed or bothered by these difficulties, since this incident?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Any reminder brought back feelings about it	☐	☐	☐	☐	☐
2. I had trouble staying asleep	☐	☐	☐	☐	☐
3. Other things kept making me think about it	☐	☐	☐	☐	☐
4. I felt irritable and angry	☐	☐	☐	☐	☐
5. I avoided letting myself get upset when I thought about it or was reminded of it	☐	☐	☐	☐	☐
6. I thought about it when I didn't mean to	☐	☐	☐	☐	☐
7. I felt as if it hadn't happened or wasn't real	☐	☐	☐	☐	☐
8. I stayed away from reminders about it	☐	☐	☐	☐	☐
9. Pictures about it popped into my mind	☐	☐	☐	☐	☐
10. I was jumpy and easily startled	☐	☐	☐	☐	☐
11. I tried not to think about it	☐	☐	☐	☐	☐
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them	☐	☐	☐	☐	☐
13. My feelings about it were kind of numb	☐	☐	☐	☐	☐
14. I found myself acting or feeling like I was back at that time	☐	☐	☐	☐	☐
15. I had trouble falling asleep	☐	☐	☐	☐	☐
16. I had waves of strong feelings about it	☐	☐	☐	☐	☐
17. I tried to remove it from my memory	☐	☐	☐	☐	☐
18. I had trouble concentrating	☐	☐	☐	☐	☐
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart	☐	☐	☐	☐	☐
20. I had dreams about it	☐	☐	☐	☐	☐
21. I felt watchful and on guard	☐	☐	☐	☐	☐
22. I tried not to talk about it	☐	☐	☐	☐	☐

31. Following a distressing incident, people often find the support of friends, relatives, neighbours and work mates very beneficial. How often are each of the following types of support available to you?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. Someone to give you practical support (*eg* take you to the doctor's or help with daily chores)?	☐	☐	☐	☐	☐
2. Someone to confide in or ask for advice?	☐	☐	☐	☐	☐

3. Someone to go out with and do something enjoyable? ☐ ☐ ☐ ☐ ☐
4. Someone to show you love and affection? ☐ ☐ ☐ ☐ ☐

F: Other accidents or incidents

The following section asks about accidents or incidents that you may have experienced in the past.

32. Have you been involved in any other distressing incidents **at work or at home** prior to this recent incident?

yes ☐ 1 ***Go to Q33*** no ☐ 2 ***Go to Q37***

33. If yes, how many incidents? (*Please write in number*) _____,

or too many to remember (happens all the time) ☐

34. Did the incident(s) involve any of the following elements (*Please tick all that apply*)

a) A road traffic accident ☐
b) Another type of accident ☐
c) A verbal assault ☐
d) A physical assault ☐
e) A dog attack ☐
f) A weapon ☐
g) A physical injury to yourself ☐
h) Witnessing or hearing about physical injury to others ☐
i) A death ☐
j) A burglary to the premises (*ie* when you were not present) ☐
k) A countersnatch or raid to the premises(*ie* when you were present) ☐
l) A theft (to your person, of mail, to van *etc.*) ☐
m) hostage ☐
n) other (*please specify*) ..... ☐

35. Have any of these other incidents occurred during the last 12 months?

☐ 1 yes ***Go to Q36*** ☐ 2 no ***Go to Q37***

36. If yes, how many incidents? (*Please write in number*) _____,

or too many to remember (happens all the time) ☐

37. Have you been involved in any other distressing incident *since* the incident we are mainly focusing on in this questionnaire? If yes, please describe it briefly in the box below including the date of the incident?

Date of incident (day, month, year) .....

Description of incident .....

.....

.....

G: Personal details

38. Are you: Female ☐ 1 Male ☐ 2

39. What was your age last birthday? *(Please write in)* ☐

40. Which of the categories below best describe your ethnic origin? *(Please tick one box only)*

White

British ☐ 1
Irish ☐ 2
Any other White background (*Please write in*) ☐ 3
.....

Asian or Asian British

Indian ☐ 4
Pakistani ☐ 5
Bangladeshi ☐ 6
☐ 7
Any other Asian background (*Please write in*) .....

Mixed

White and Black Caribbean ☐ 8
White and Black African ☐ 9
White and Asian ☐ 10
Any other Mixed background (*Please write in*) ☐ 11
.....

Black or Black British

Caribbean ☐ 12
African ☐ 13
Any other Black background ☐ 14
(*Please write in*) .....

Other Ethnic groups

Chinese ☐ 15
Any other background (*Please write in*)..... ☐ 16

41. Do you have a long-term health problem or disability which substantially limits day-to-day activities?

yes ☐ 1 no ☐ 2

Comment

If you have any comments or information that you would like to add, please write in the box below.

.....
.....
.....
.....
.....
.....

This study is designed to investigate how successful different management practices are in reducing the distress caused by accidents and incidents at work. In order to investigate this thoroughly we need to know about your personal experience and circumstances. If any of these questions seem intrusive please bear with us and accept our assurance that all replies will be treated as strictly confidential. No replies will be used in such a way that anybody could be individually identified.

Appendix 2: Interview Schedule

Now, returning to [EVENT], I'd like to ask you about what happened after that, in terms of the response from the organisation to the incident.

Initial support

1. Can you tell me what support you had from the organisation following the incident? What contact did you receive? From whom?
2. What did you think of that support?
3. What other sources of support did you have? From where? What kind of support?
4. Did you have time off after the incident (to recover)? How long? Are you back at work now?

Process of returning to work

Use one of the three sections below

Some time off but back at work now

1. Have you returned to the same job? Different job in organisation? Similar job in another organisation?
2. Did you have any contact from the organisation (Royal Mail and its companies) during the time you were off? What kind of contact? Who contacted you and what was the purpose? (to provide support, to provide information, for personnel or administrative reasons, friends, etc.)
3. What do you think helped you to recover from the incident? (Refer to specific organisational contact if necessary)
4. Was there anything that you think made it more difficult for you to get better? (Refer to specific organisational contact if necessary)
5. Did you have any sources for support or information from outside the organisation during the time you were off? Who? (Friends, Family, GP, Union etc.)

NB What were the messages that they heard from each of those groups (manager, colleagues, union, EHC, own GO, etc.)

Can you remember deciding to return to work? Was there a particular trigger? Can you remember what it was that made you decide it would be okay to go in on that day? What was different from the day before?

Not yet back at work

1. How do you now feel about returning to work?
2. Have you had any contact from the organisation (Royal Mail and its companies) during the time you were off? What find of contact? Who contacted you and what was the

purpose? (to provide support, to provide information, for personnel or administrative reasons, friends, etc.)

3. Do you think any of this contact has helped you get better?
4. What other sources for support or information from outside the organisation do you have available to you? Who? (Friends, Family, GP, Union etc.)

No time off

1. How did you feel about going in to work the next day?
2. Was there anything that made it easier?
3. Was there anything that made it harder?

Perceptions of the job (changes in)

NB This is about interviewee's current perceptions of the job, so they may be able to answer these question even if not back at work.

1. Do you perceive (think/feel) that the job is riskier than you previously thought?
2. Do you do [or do you think you would do] anything differently now at work, that you didn't do before?
3. Is that just something you have started to do or have you been instructed to do something differently? Does that cause any problems in the job? Have you received any assistance from work with that?
4. Do you think that you are [would be] treated any differently than before by your work colleagues? In what ways?
5. How do colleagues generally respond when someone's been off work for a while?
6. Has the incident changed you? How are you different now – what changes in you as a person? How do you think that affects you at work [would affect you at work]?

The future

Again interviewees may be able to answer these questions even if not back at work.

1. After the incident, did you expect anything to change at work, in the way jobs are done? What did you expect would change? Where did that expectation come from? *(did they hope a incident would prompt some organisational reaction, or were they lead to believe something would change)*
2. Did anything change? What's the reality, how does that affect you?
3. What would you like to see done differently in the future, in terms of how things are done? What else should be/could be done?

4. If not already covered) how about the way the organisation responded, the procedures after the incident? Were you satisfied with the organisational response? What should change in the organisation's responses and procedures?

Finally ….

If there was one thing the organisation could have done [could do] to help you recover/get back to work more quickly what would it have been [would it be]?

Thank you & close

Remember to provide them with the EHS Helpline number

08457 994400

or any of the other numbers provided on your contact sheet, if appropriate.