Despite the widespread use of psychological debriefing in a variety of settings, particularly in emergency services, there is a body of scientific research that questions its effectiveness, and, in some instances, researchers have asserted that the practice may be harmful (Raphael, Meldrum, & McFarlane, 1995; Rose, Bisson, & Wessely, 2001). Therefore, it is timely to consider an alternative intervention for emergency services workers that provides them with an appropriate level of protection from the negative psychological sequelae of exposure to traumatic experiences, an intervention that is not harmful, and can be shown to be beneficial. It is proposed that the model presented in this article, integrated with employee education and training, provides such a service.

Appropriately selected, trained, and supervised peer supporters form the key component of the Queensland Ambulance Service Employee Assistance Program (EAP) known as Priority One. Initiated in 1992, Priority One has progressively shifted emphasis away from the practice of debriefing as described by Mitchell (1983) while retaining the benefits of coworker support, which is suggested to be beneficial in offering stress-buffering attributes within a larger EAP (Beaton, Murphy, Pike, & Corneil, 1997; Regehr, Goldberg, & Hughes, 2002). Initially, a review of the literature that explains the current proliferation of the Critical Incident Stress Management (CISM) model (Mitchell, 1983) is presented, including evidence that suggests CISM is not necessarily in the best interests of emergency service personnel. The article then provides a summary of an alternative integrated peer support model and includes early evidence that is very encouraging for the effectiveness of the model.

Trauma Exposure

Individuals who are exposed to extreme psychological trauma are at risk of suffering some psychological deficit (Herman, 1992). *War neurosis*, as it was termed following the World War I, was a condition seen to affect a significant proportion of soldiers returning from the battlefield (Herman, 1992). It was not until 1980, however, that the psychiatric community granted official recognition to sufferers of this condition and the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; *DSM-III*, APA, 1980) when the manual included the first label and definition of Posttraumatic Stress Disorder.

Keywords

paramedics, emergency medical dispatchers, peer support officers, PTSD, trauma, debriefing

1Queensland Ambulance Service and School of Psychology and Counselling Faculty of Health, Queensland University of Technology, Brisbane, Australia

Corresponding Author:

Paul J. Scully, Manager, Staff Support Services—Priority One, Queensland Ambulance Service GPO Box 1425, Brisbane, 4001, Australia

Email: paul.scully@dcs.qld.gov.au
(PTSD). This move was, in part, a response to the increasing prevalence of this condition in Vietnam veterans as described by the Vietnam Veterans Administration (Herman, 1992).

The American Psychiatric Association (APA, 2000) asserted that community studies revealed the lifetime prevalence of PTSD ranging from between 1% and 14%. However, in populations defined as at risk (e.g., combat veterans, victims of natural disaster, or criminal violence) the lifetime prevalence rates of experiencing trauma have been noted as up to 58% (APA, 2000). This broad range risk can be understood by considering that PTSD can develop from a wide variety of stressors, including the intensity of the traumatic event and the proximity of the individual to the event. Therefore, the largest rates of PTSD could be expected to be seen in populations who are at close proximity to the most extreme of traumatic stressors such as emergency services workers.

**Individual Crisis Intervention**

Approaches to assist individuals following traumatic experiences have focused on early intervention as a way of preventing later psychological distress. There is no single model used in this approach; rather, health care professionals use a variety of counseling/psychotherapy techniques to help the individual who has experienced a critical incident to mobilize their own coping mechanisms in order to prevent long-term psychological morbidity. This individual approach focusing on coping, loss, and grief was originally developed by Lindemann in 1944 and was broadened by Robinson in 2000 to incorporate more general traumatic and stressful events rather than purely grief and loss (Robinson & Murdoch, 1998). The aim of these approaches was to intervene before maladaptive cognitive and behavioral coping patterns had become entrenched. More recent work by Bryant, Moulds, and Nixon (2003) examines the use of cognitive behavioral therapy (CBT) and proposes high levels of success in the early treatment of acute stress disorder and PTSD.

**Group Crisis Intervention**

Critical incident stress debriefing (CISD) as an intervention has its roots in psychoanalysis with the notion of catharsis (Carlier, 2000), starting from the assumption that giving an individual the opportunity to vent emotionally will promote psychological healing and reduce the likelihood of developing PTSD (Mitchell & Everly, 1996). It is thought that the group environment provided by CISD gives social support, normalizes the experience of trauma, provides information about the specific trauma and about further support services available, and gathers information about the traumatic experience for the group members (Carlier, 2000).

There appears to have been no consistent model or format in approaching crisis intervention specific to emergency services that predates the approach offered by Mitchell in 1983. Following the evolution of group CISD there emerged a multicomponent program known as critical incident stress management (CISM; Everly, Flannery, & Mitchell, 2000). Although the term “Employee Assistance Service” or “Employee Assistance Program” may be more familiar terminology in nonemergency service organizations, CISM has been a culturally acceptable term in many emergency services. The evolution of CISM specifically gives a high profile to psychological debriefing.

The goals of debriefing are similar to individual intervention approaches in that they attempt to prevent individuals from entering into maladaptive coping responses to critical incident stress (Robinson & Mitchell, 1993). There are four popular models of debriefing: Mitchell’s model of CISD (1983), Raphael’s (1986), Dyregrov’s (1989), and Armstrong, O’Callaghan, and Marmar’s model (1991). Rose and Tehrani (2002) point out that these four models of psychological debriefing are now well known, and this appears to have led to the increased use of psychological debriefing in lay populations, including with women following stillbirths, road traffic accident victims, and assault victims.

Raphael and Newman (2000) assert that the extensive and wide-ranging use of the debriefing model has been erroneously applied to a broad constituency and that any effectiveness may be in stress management in an occupational health setting or for emergency and related services. Bisson, Jenkins, and Alexander (1997) examined psychological debriefing of victims of acute burns trauma and claim the debriefing group were worse at follow-up than the control group. Hobbs, Mayou, Harrison, and Warlock’s (1996) study of motor vehicle accident victims also involved random allocation to intervention and control groups and showed no benefit for prescriptive individual debriefing in preventing psychological morbidity. The Cochrane review of debriefing for the treatment of immediate trauma-related symptoms and prevention of PTSD concluded that these studies, and many others, meet criteria for inclusion in terms of scientific quality; however from their meta-analysis, the review’s authors concluded the practice of psychological debriefing was not useful in the prevention of PTSD (Wessely, Rose, & Bisson, 1998) and was potentially a mechanism for compounding the potentially deleterious effects of trauma.

The Cochrane report (2002) also described the risk that psychological debriefing may “pathologize” normal distress and suggested that it may also increase the expectancy of developing psychological symptoms in those who would otherwise not have done so. No matter how great the trauma is, a constant finding of the traumatic stress literature indicates that not everyone develops psychological distress and it is usually only a minority who progress to a formal, diagnosed long-term psychiatric disorder. Similarly, the authors suggest that debriefing also assumes that there is a uniform, and to a certain extent, predictable pattern of reactions to trauma. This view is shared by Bisson et al. (1997), Shalev (1992), and Stuhlmiller and Dunning (2000). The Cochrane report and authors such as those just noted, suggest that recalling the event may be a secondary trauma in itself.
Attempting to forget or distance oneself may indeed be an adaptive response, and an intervention such as psychological debriefing may interfere with adaptive defense mechanisms (Raphael, 2000).

A further problem is that debriefing, by definition, focuses on a single trauma. However, even if all the victims of a disaster were exposed to a uniform event they are certainly not uniform in any other respect. Focusing attention on the single traumatic event may divert attention away from other important psychosocial or nontraumatic factors that differ between people (Rose et al., 2001). Rose and Tehrani (2002) observe that a review of psychological debriefing brings into focus the fact that humankind has had to deal with death, injury, and disasters throughout history. They go onto suggest that there appears to be an inherent wish for those who have suffered to be able to tell others of their experiences and suggest there are a number of different purposes for this, which might include being recognized for doing a good job, making the event more understandable, gaining sympathy and support, identifying ways to cope better, being informed about the event and potential reactions, meeting and learning from others who have suffered in similar situations, handling guilt and shame, being understood and forgiven, and helping others by sharing skills.

Similarly, Raphael et al. (1995) in their earlier work to ascertain whether debriefing after psychological trauma works in alleviating symptoms of distress, posed a number of similar reflections. They concluded that debriefing may be perceived positively because it meets many needs, the needs of those not directly affected to overcome their sense of helplessness and the guilt of surviving, to make restitution, to experience and master vicariously the traumatic encounter with death; the needs of those directly affected to speak of what has happened, understand it, and gain control; and the symbolic need of workers and management to assist those who suffer and show concern.

Given the findings of the questionable, if not negative, consequences of debriefing in the studies cited above and the reflective observations made by Wessely et al. (1999), Rose and Tehrani (2002), and Raphael et al. (1995), it is clear that factors such as peer support, which have yet to be critically evaluated scientifically, feature in what individuals and organizations perceive to be beneficial to them or to their employees following exposure to traumatic incidents. Furthermore, much of the information implied or inferred in the rhetorical questions by these authors relates specifically and peculiarly to individuals suffering personal trauma who are not professional emergency services workers but who are victims of either a significant disaster or a very significant personal circumstance that has profoundly impacted upon them. The point must be made that emergency services personnel in general, and ambulance personnel in particular, encounter individuals in crisis on a daily basis as a result of tragedies but in the main, they cope with, and perform well. The work undertaken by Shakespeare-Finch, Smith, Gow, Embelton, and Baird (2003) has provided evidence for the co-occurrence of posttraumatic growth and distress in ambulance paramedics. Similar work by Regehr et al. (2002) has indicated the benefits of peer support and support from mental health professionals for paramedics and that it is appropriate to reconsider approaches to employee support and to scientifically evaluate programs currently being used.

In findings related to the peer support role and the application of psychological debriefing, Pender (2006) undertook a qualitative analysis of emergency service responders following debriefings. From the study key factors cited in the results indicated that themes contributing to resolution included “connection to peers” as well as support from family members, recognition of good enough effort, and accepting human limitations. In work by Watchorn (2002), who examined emergency services personnel following a massacre in which a gunman shot and killed 35 people and injured 30 others in a rampage at a tourist venue, it was revealed that one of the most significant factors influencing the outcomes for emergency service personnel involved in debriefing was that they knew a peer supporter officer (PSO) in attendance and/or the professional counselor in attendance at the debriefing. Knowing a PSO or counselor also influenced whether the emergency personnel attended the sessions or not. Watchorn’s findings lend further weight to benefits that accrue to emergency service workers who perceive they are cared for and supported by peers.

**Emergency Service Workers**

Although emergency services personnel are not without feeling for, and sensitivity to, the individuals for whom they care within the usual context of their duties, they cope on a daily basis with a remarkable frequency of exposure to events that otherwise in the life of a nonemergency services person would be regarded as overwhelming and distressing, if not abhorrent. This apparent contradiction between the way in which people in emergency services cope, and the way in which members of the wider community might cope with similar circumstances, leads inevitably to the need to understand the nature of emergency services workers and why and how this group of individuals copes with their work.

This daily demand on ambulance paramedics and their apparent resilience to potentially traumatic experiences leads inevitably to the question of how they manage these challenges. Hetherington (2001) observed that working for emergency services is a challenging and potentially highly rewarding vocation, yet the nature of the job makes it one of the most stressful occupations. Hetherington points out that cumulative stress and the trauma of the job can have damaging effects on officers’ personal and professional lives, yet the unpredictability of the amount of work, and of the type of work in the emergency services, even if it is considered a source of stress, are found to be attractive features of the role (Hetherington, 2001; James, 1988). Hetherington also suggests
emergency professionals tend to have high levels of commitment, challenge, and control and are more resilient to stress.

In her examination of ambulance paramedics in Australia, Shakespeare-Finch et al. (2003) found that growth occurred for many paramedics following a traumatic event. In this research the rate of positive change was reported far more frequently than negative posttrauma changes. The study also revealed that trained peer support officers scored more highly on the Post-Traumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) than personnel who were not trained as peer support officers. Shakespeare-Finch and colleagues suggest that there is a need to normalize the positive legacy of trauma in the same way that negative reactions in the short term are regarded as normal. This gives rise to the importance of providing preincident education for personnel, particularly at the time of recruit training, as well as postincident education for personnel following critical events. Pre- and post-incident education are essential elements of the wider EAP program and are pivotal in building resilience. This point is also fundamental in the recommendation by Bisson and Cohen (2006) who assert that education is the first of a series of steps in a stratified care model.

The scientific literature reviewed as part of this article questions the appropriateness and validity of stand-alone debriefing and, in some instances, has found that such approaches are toxic practices (Arendt & Elkit, 2003; Rose, 1997; Wessely et al., 1999). Research by Regehr et al. (2002), Shakespeare-Finch et al. (2003), and Beaton et al. (1997) indicates the benefits of social support in general, and work colleague support in particular, in the promotion of psychological health within an emergency service context. In addition, research by Orner and colleagues (2003) specifically identified the preference for emergency services personnel to “talk” with a known colleague/peer following the event to maximize well-being and adjustment following particularly difficult work-related situations. As far back as 1987 Figley proposed that “social-support resources can be critical to a victims recovery [and] . . . Therefore, it is valuable to teach trauma workers . . . how the five components of social support can benefit.” A fundamental element of Figley’s five-component proposal is the workers understanding of companionship, and work/family systems and connections. This speaks to the necessity of emotional connectedness and the need for opportunities to “talk” safely. The following section describes an alternative to existing programs that has been developed over nearly 20 years and has been subjected to repeated evaluative scrutiny.

**Toward a New Direction**

**The Context**

The Queensland Ambulance Service (QAS) has an operational staff (Paramedics & Emergency Medical Dispatchers) of 3,120 personnel and responds to approximately 840,000 cases annually (Queensland Government, Department of Community Safety, Queensland Ambulance Service, 2010c), serving a population of approximately 4.3 million. Of this number of responses, approximately 72% are categorized as “Code 1”—being most urgent and life threatening. Not uncommonly, those that are rated as less urgent (Code 2 or Code 3) on initial evaluation may be upgraded (to Code 1) upon attendance by paramedics.

The EAP presented in this article is embraced and supported by the organization and is spearheaded by a high-profile, well-trained, and readily accessible group of peer support officers (PSOs). The model of intervention developed by the QAS offers the availability of trained PSOs located in all regions of the state and many of the 287 QAS stations. A key benefit of this particular approach appears to be that personnel are likely to be well known to PSOs as they often work in and live in the same general locality. Such a familiarity also enables personnel to proactively seek out the PSO for assistance and guidance when needed. The QAS has had a comprehensive, broad-based, stratified EAP and Trauma Counseling program (Priority One) for ambulance personnel since 1992. The program includes (a) face-to-face counseling, (b) 24-hr telephone counseling, (c) peer support program, (d) psychological debriefing, (e) chaplaincy service, (f) indigenous support service, (g) gay and lesbian support service, (h) mental health—resilience building education—recruit and manager/supervisor. The QAS employs 3 full-time counselors and utilizes approximately 40 external counselors throughout the state.

Of the various elements of this EAP the focus in this paper is the peer support officer program, in particular the way in which this role functions given the unique structure and nature of PSO training and the nature of engagement with personnel by PSOs. It is essential that the concept of peer support be considered one of the strengths of this EAP program in particular and the overall culture of the organization. This feature is considered one of the strengths of this program.

**Key Features of the Peer Support Program**

The concept and usefulness of the peer support officer program within the organization is embedded in the earliest possible education provided to new recruits. During initial recruit training personnel undertake study units on occupational stress. These units consist of a series of lectures and assessment measures intended to build resilience and to establish basic ground work for stress-buffering and healthy resilience-building and coping strategies for self-care. This study program includes, but is not limited to, the following topics: basic concepts of human stressors; fight and flight; causes of stress in the (ambulance) workplace; individual stress reactions; coping with stress; controlling stress in the workplace; managing stress in the work environment; phys-
ical, cognitive, and emotional indicators of distress; impact of distress; workplace distress on the individual and family members; loss and grief; coping with stressors relating to shiftwork and fatigue; effective communication in hostile environments; communication to minimize distress; and support services/resources available to assist personnel in the workplace (Paramedic Studies, QAS Education Centre, 2002).

Assessment of this component of new recruit education includes written assignments, workbooks, workplace reports, with special emphasis on the completion of a journal identifying significant cases that the student paramedic attends in the first 6 months of their (on road/operational) duties. The student journal requires the recruit to record both positive and negative experiences/reactions/responses flowing from cases that they attend. The student is then required to discuss these experiences and their responses to them with a trained peer support officer.

This approach creates an opportunity in which a student paramedic can interact with a peer support officer in a non-critical, positive context providing the opportunity not only to discuss responses but also to establish a rapport with the “first link” in the larger chain of mental health care and support within the organization. This intervention adds significantly to the establishment of a rapport with a peer support person located in or near the student officers’ workplace and in doing so lays early groundwork to minimize mental health stigma and, more importantly, to engage the student in a positive proactive approach to his or her own mental health care, thus promoting psychological resilience in the student (Paramedic Studies, QAS Education Centre, 2002). These components of assessment are regarded as critical and represent a pivotal component of the early development of resilience building as well as promoting a positive attitude toward the use of support services.

An additional complimentary element of the wider Staff Support program is an extensive Manager and Supervisor Mental Health (Support) education program, which is mandatory for all managers and supervisors. The program focuses on understanding reactions to stressful events and alerts management to behaviors to watch for in staff members as well as interventions to assist staff. It provides clarity around when and how to assist staff (including themselves) to access appropriate resources and under what conditions these resources should be mobilized.

**Peer Support Officer Selection and Training**

Prospective peer supporters are required to complete a rigorous selection process beginning with a written application form. Short-listed candidates then undertake an interview and must complete an induction training program, all of which constitute an assessment and screening process. The screening process is designed to ensure that (a) the applicant is sufficiently robust to provide support to another individual; (b) the applicant is not suffering posttrauma symptoms or other conditions that might be exacerbated as a result of the peer support officer role; (c) the applicant is capable of and willing to be available to assist work colleagues in what may be difficult and confronting circumstances; (d) the applicant is able to work effectively to make a judgment about the limits of his or her role as a peer supporter and refer appropriately; and (e) the applicant can and will grasp an appropriate level of regard for confidentiality, ensure the protection of confidential information, and will report/seek assistance in the event of critical or life-threatening matters such as threatened suicide.

Peer support officer recruit training is conducted over a 6-day residential and carefully facilitated training program by professional mental health workers. Participants undertake both small (intimate) group and large group experiences facilitated by qualified mental health care professionals modeling interactions with individuals in crisis as well as providing opportunities for participants to identify specific issues and areas of personal difficulty that they may have. Training also provides extensive opportunities for skills development and for understanding core concepts of the role of peer support, including:

1. **Effective communication skills:** This forms the basis for individuals to discover the idiosyncratic nature of their own communication and that of others and the necessity to develop attending skills that are essential in effectively engaging with work colleagues in crisis.

2. **Essential counseling skills:** This training embraces core micro skills for individuals working in an essentially support environment. Skills include but are not limited to paraphrasing and reflecting skills, attending skills, questioning, providing feedback, and various other micro skills as described by Hetherington (2001).

3. **Knowledge of the participant’s own experience with loss and grief and ways in which participants may support work colleagues in their encounter with bereavement.**

4. **Concepts of stress and distress, critical incident stress, acute stress disorder, posttraumatic stress disorder, including developing within the participant an understanding of his or her own experiences with occupational stress and ways in which this experience may assist work colleagues.**

5. **Knowledge and understanding of shiftwork and healthy approaches to physical and mental health within the context of ambulance service work, shiftwork, and fatigue.**

6. **Understanding suicide/suicidal behavior.**

7. **Confidentiality and ethical behavior within the peer support role.**
Upon completion of this selection and recruit training, peer supporters are required to complete a 6-month probationary period during which time they are mentored by another serving peer support officer and supervised by a professional counselor.

Peer Supporter Supervision

Supervision represents an essential feature of the PSO role. Peer support officers are required to commit to be bound by a QAS Peer Supporter Code of Conduct that identifies critical issues such as confidentiality, reporting of information, and of the special importance of attendance at supervision. Specifically, peer support officers are required to attend monthly group supervision as well as including a minimum of two individual supervisions with a mental health care professional each year. Supervision also provides ongoing skill development and mental health education. Peer supporters are also required to attend an annual 3-day skills maintenance/development workshop.

In a study of peer support supervision within the Queensland Ambulance Service, Bensley (2003) found high levels of satisfaction within trained peer supporters for clinical supervision, both in group and individual form. Supervision provides education, counseling, personal support, and skill development (Holloway & Carroll, 1999; Spence, Wilson, Kavanagh, Strong, & Worrell, 2001). It must be borne in mind that a high level of duty of care falls to the employer in such circumstances where support for work colleagues is provided on a voluntary basis. This responsibility adds a compelling argument for the necessity of regular mandated supervision of PSOs. Both the quality of care provided by PSOs and the individual providing the care must be carefully monitored through supervision to ensure that both the support is appropriate and that the boundaries and limitations of the peer supporter are not exceeded. An additional feature ensuring careful monitoring of supervision and other elements of the wider program is an annual counselor’s workshop providing a forum for contemporary updates, organizational feedback, and monitoring of services provided by counselors.

The combination of careful selection, recruit, and ongoing training and mandatory supervision for peer supporters augments the operational experience of PSOs and their level of credibility within the occupational setting in providing support for work colleagues. This combination ensures that PSOs, as the first line of contact in the chain of support, are regarded as credible and authentic within their support role.

Peer support officers are located in or near most ambulance stations in the state. This provides ready access to support personnel while also providing PSOs with a high level of awareness of critical incidents within the area enabling appropriate proactive support. More than 390 paramedics and EMDs have been trained as PSOs in the life of the program, with approximately 110 active as PSOs at any time. The usage data informing the following statistics were collated from nonidentifying (activity) data reports provided by trained PSOs and by professional counselors external to the organization; these data are collected to inform the organization about usage of services and to sustain support for services provided. Early data collected over a period of 7 years, between 1994 and 2001 (QAS Staff Support Service Data), indicated that although 37% of the occasions on which individuals sought or were provided with post-incident support by PSOs was for trauma (e.g., gross trauma, multicasualties), a further 33% of instances in which paramedics received postincident support were as a result of injuries and death involving children. This trend continued in the period 2009-2010 (QAS Staff Support Service Data 2009-2010). These data provide support for proactive follow-up of personnel utilizing dispatch data and for having an on-call “duty” peer supporter in defined geographical regions.

In a comprehensive study of satisfaction with this EAP and the various arms of the program, personnel (N = 667) reported high levels of satisfaction with all aspect of the program (Shakespeare-Finch & Scully, 2004). More than half of the staff in this research utilized the available support services with high to very high satisfaction ratings recorded by individuals who had accessed the professional counseling service, the peer support officer service, or both. The level of engagement by personnel with peer supporters is indicative of the high level of acceptance of this and other services.

During the 2009-2010 period, 779 personnel individually accessed external counseling services that are part of the Priority One program. Peer support officer contact was made by 1,510 personnel; a number of these contacts occurred following PSO activation in response to 177 identified critical events (QAS, 2010a). Perhaps more compelling data supporting the efficacy of this model of intervention can be found in the decreasing frequency of diagnosed work-related PTSD. Diagnosed PTSD has declined 41% between 2005-2006 and 2009-2010, with only 5 cases diagnosed in 2009-2010 (QAS, 2010b). More important, this trend has been concurrent with an increase in operational staff of more than 40% from 2004 to 2010 (QAS, 2010c), and an annual increase in patient case load in the same (6-year) time frame of approximately 7% (QAS, 2010c). Hence, the prevalence rate of PTSD in this ambulance service for the 2009-2010 period stands at only 0.0016% recorded by an independent body (QAS Workcover Data).

The Priority One program has also withstood legal scrutiny. In Hegarty vs. the Queensland Ambulance Service the Priority One Program was described by Justice Douglas as meeting its duty of care as follows: “The Priority One programme was a serious attempt to discharge the obligations placed on the defendant as an employer” (cited in Freckleton, 2008).

Priority One, as described in this article, has consistently encouraged transparency and enhancement based on research. Various aspects of this program have been the subject of
approximately 15 postgraduate research projects revealing an array of information regarding matters relating to the mental health and well-being of this emergency service population and led to at least 10 publications. In addition to preliminary scientific support for the efficacy of this program, industry recognition of its validity and applicability for this and similar populations has flowed from other organizations seeking to replicate the model. The author has been seconded to and/or consulted with other government departments and nongovernment organizations, in order to duplicate this program for other critical care organizations (e.g., Department of Child Safety, Qld). The author has also worked with the London and Northumbria Ambulance services in the United Kingdom, establishing peer support programs, and has consulted to the Scottish Ambulance service in Edinburgh.

**Conclusion**

This article has outlined some salient literature relating to debriefing for emergency service workers and the arguments against the efficacy of such an approach. The benefits some claim to have gained from debriefing are more likely to accrue not from the debriefing itself but from the social support, genuine empathy, and interest shown by work colleagues or peers who are trained to provide support for individuals at the time of the debriefing. Given the examination of debriefing literature, and against the background of emerging research indicating the positive aspects particularly of trained peer supporters, this article has briefly outlined a comprehensive EAP that is constructed around a highly resourced peer support model. Given the scientific research and the promising user data and self-report information provided by employees themselves, this model focuses on a new direction that moves away from the reliance on debriefing and promotes the benefits of a support model offering resources that are available to personnel not only following a work-related critical incident but also in other circumstances within the general occupational context or in their personal lives. Further longitudinal research now needs to be undertaken in order to more rigorously validate what appears to be an extremely effective workplace support program.

**Acknowledgments**

I wish to thank the peer support officers of the Queensland Ambulance Service for the many thousands of hours of volunteer work they undertake in selflessly caring for their colleagues and for their genuine and unconditional commitment to training and supervision so that they may reach their potential and assist others to reach theirs in the challenging work they do.

**Declaration of Conflicting Interests**

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Funding**

The author received no financial support for the research, authorship, and/or publication of this article.

**References**


Queensland Ambulance Service. (2010a). *Staff support services (EAP) user data*. Brisbane, Queensland, Australia: Author.


