— CRISIS & TRAUMA RECOVERY GROUP —

THE MISSING EARLY RESPONSE AFTER SERIOUS INCIDENTS

What should happen first after a serious incident

EXECUTIVE SUMMARY

Across sectors where serious incidents occur, organisations often refer affected people directly to counselling or specialist trauma treatment. However, national and international guidance and evidence do not support either as the automatic first response for everyone affected [28,29,35,46,47]. Used automatically, these referrals may leave managers without a clear plan for what happens next: whether the person is safe to continue working, which duties or routines are affected, what temporary adjustments or practical support are needed, who will coordinate them, and how the person's continuation or return will be reviewed [19,28,29,35,47–49,67].

In the first hours, days and weeks, organisations must establish what has changed, what is unsafe, what the person can no longer do safely or reliably, and what action is required now.

Managers should begin ordinary organisational support immediately and coordinate the response. Where additional structured support is needed, begin with a qualified clinical early response (e.g. CS-Return), alongside appropriate organisational, practical and medical support. Add specialist trauma treatment when indicated. Urgent medical or safeguarding action takes priority [19,28,29,35,47–49].

1 WHY THIS MATTERS TO ORGANISATIONS

Poor coordination following serious incidents can lead to unsafe decisions, repeated referrals, additional management time, staffing disruption and unnecessary costs. Mental-health-related sickness absence also has substantial policy and economic significance, and workplace interventions can support return to work [67–70]. People exposed to serious incidents may repeatedly be asked to describe the incident while receiving little practical help with sleep, safety, work, travel, family responsibilities or return to role. Repeated or unnecessary requests to describe the incident in detail can increase distress [11,46,76,77] and can also divert attention from what needs to happen next. Services should therefore monitor safe functioning, sustainable return, absence, repeated referral, management time, costs and user trust—not symptoms alone [21,67–70].

2 QUALIFIED CLINICAL EARLY RESPONSE

Where ordinary support is not enough, CTRG recommends a qualified clinical early response covering the six connected functions below. CS-Return is one integrated example.

1 Assess current impact, risk and priorities	4 Coordinate relational, practical, organisational and multi-agency action
2 Stabilise safety and functioning	5 Review what changed in real life
3 Support safe continuation, adaptation or return	6 Re-assess and decide next steps

CS-Return integrates two purposes: stabilise what is unsafe or disrupted, and support safe continuation, adaptation or return to the exact role or routine affected. These begin together. Support may address sleep, physical health, thinking, travel, work, caring responsibilities, temporary adjustments and coordinated practical, medical, workplace or family action [7,9–11,18,19,21,33,36,39,41,43,45,47–49,67]. The same functions can apply in a new crisis, destabilisation of an existing trauma-related condition or a longer trauma pathway.

People should not have to describe serious incidents in detail before receiving help. For more than a century, crisis management has emphasised restoring safety, functioning, resources and connection with ordinary roles [19,47,49,71–73]. Therapeutic work involving deliberate recall or processing of potentially traumatic memories should occur only where assessment identifies a continuing clinical need [11,28,29,35,46,47].

3 IMPLICATIONS FOR COMMISSIONERS

Commissioners need providers able to deliver all six functions, maintain continuity, support safe continuation, adaptation or return from the first session and review real-life outcomes.

Counselling, peer support, MHFA, TRiM, CISM/CISD, screening and referral must not be used as substitutes for a complete qualified clinical early response. Providing one of these does not mean the crisis has been managed. These approaches and processes have different purposes; evidence and guidance do not establish them as interchangeable with the integrated response specified in this briefing [5,16,22,26,35,44–47,65,66,93]. Where ordinary support is insufficient, CTRG recommends commissioning all six functions, with clear responsibility for action, coordination and review. Specialist trauma treatment should address an assessed clinical need and must not replace necessary crisis action [19,27–29,35,45,47–49].

CORE MESSAGE

Do not default to counselling or specialist trauma treatment, or rely on peer support, MHFA, TRiM or CISM/CISD as the complete response after serious incidents. Where structured support is needed, begin with a qualified clinical early response (e.g. CS-Return), without requiring detailed retelling before help is provided.

CRISIS & TRAUMA RECOVERY GROUP

VISUAL OVERVIEW FOR MANAGERS AND COMMISSIONERS

THE MISSING EARLY RESPONSE AFTER SERIOUS INCIDENTS

What should happen first after a serious incident

- Protect people early
- Maintain safe operations
- Support functioning and participation
- Improve coordination and continuity
- Avoid mismatched referral and unnecessary escalation

THE PROBLEM

After a serious incident, some people may be overwhelmed or unable to function safely.

Severe distress does not automatically mean PTSD. Counselling and specialist trauma treatment should not be automatic first responses after a crisis.

Premature counselling or specialist trauma treatment involving detailed retelling may be unhelpful and can be harmful for some people.

WHAT SHOULD HAPPEN FIRST

Begin ordinary organisational support immediately.

Where additional structured support is needed, begin with a qualified clinical early response (e.g. CS-Return).

Add specialist trauma treatment when indicated.

Urgent medical or safeguarding action takes priority.

USUAL EARLY-RESPONSE WINDOW

Day 1 (start) — 6 weeks (approximately) — 2 months (sometimes)

Usually started as early as possible, from Day 1 to about six weeks, sometimes later. Sessions may continue longer as needed.

HOW QUALIFIED CLINICAL EARLY RESPONSE WORKS (e.g. CS-Return)

Six connected functions that work together — not six separate steps or sessions.

1 ASSESS IMPACT, RISK & PRIORITIES

Function 1

- What changed?
- What is unsafe or disrupted?
- What needs action first?

2 ACT ON WHAT IS DISRUPTED

Function 2
Stabilise safety & functioning
Restore enough safety and regulation for day-to-day functioning.

Function 3
Support safe continuation, adaptation or return
Help safe re-engagement with the affected role, place, relationship or routine.

Function 4
Coordinate relational, practical, organisational & multi-agency action
Address barriers and link the right support.

3 REVIEW & DECIDE NEXT STEPS

Function 5
Review what changed in real life
What improved? What remains disrupted? Did agreed actions happen?

Function 6
Re-assess and decide next steps
Continue, adjust, close, hand over or arrange separate specialist treatment.

If needed, real-life change informs the next cycle.

RELEVANT ACROSS CRISIS-EXPOSED SECTORS

Aviation and Transport | Police and Emergency Services | Fire and Rescue | Military and Defence | Criminal Justice, Forensics & Legal | Education | Workplaces and Industries | Humanitarian and Community | Health and Social Care

CORE MESSAGE

Do not default to counselling or specialist trauma treatment, or rely on peer support, MHFA, TRiM or CISM/CISD as the complete response after serious incidents. Where structured support is needed, begin with a qualified clinical early response (e.g. CS-Return), without requiring detailed retelling before help is provided.

CRISIS & TRAUMA RECOVERY GROUP (CTRG) POLICY RECOMMENDATIONS

1. Start with what the incident has changed. Check safety, sleep, physical health, thinking, travel, work, caring for others and everyday responsibilities. Identify what is causing difficulty now and what help or change is needed.

2. Decide what support is needed. Start ordinary organisational support immediately. Act without delay for urgent medical, mental-health or safeguarding risks. If ordinary support is not enough, begin a qualified clinical early response (e.g. CS-Return) and add specialist care where needed. More than one response may be needed.

3. Use the right professional. The qualified clinical early response must be delivered by an appropriately qualified and experienced mental-health professional able to assess needs and risks, stabilise, support safe continuation, adaptation or return to work and everyday life, coordinate help and decide what happens next. Managers do not diagnose.

4. Commission the whole response—not a label or programme. Where qualified clinical early response is needed, commission all six connected functions: assess current impact, risk and priorities; stabilise safety and functioning; support safe continuation, adaptation or return; coordinate relational, practical, organisational and multi-agency action; review what changed in real life; and re-assess and decide next steps. CS-Return is one integrated example, normally comprising one to four sessions, with an exceptional fifth session for transition or handover only. A therapy, programme or support label is not a substitute for this response. Where treatment is needed, a qualified clinician should decide what is appropriate; treatment must not replace necessary safety, practical, coordination or return-support actions.

5. Support safe continuation, adaptation or return from the first session. Focus on the actual duty, journey, place, relationship, family responsibility or routine affected; put the right support around it and agree practical steps, temporary changes or gradual re-engagement that support safe continuation, adaptation or return as early as appropriate.

6. Do not require detailed retelling before providing help. Psychological debriefing can be harmful, and counselling may also increase distress where it involves unnecessary or repeated detailed retelling. Ask only what is needed to keep the person safe, decide what help is needed, or meet legal or safeguarding duties.

ASK THE PROVIDER:
After a serious incident, what exactly will you do, who will be responsible for each action, and how will you support safe continuation, adaptation or return to work and everyday life?

The evidence and rationale supporting these recommendations are set out in Parts I and II.

CONTENTS

ABOUT THIS BRIEFING

Who this briefing is for

This briefing is for people who decide, commission, coordinate or oversee organisational responses after serious incidents, across public services, workplaces, transport, emergency services, health and social care, defence, justice and community settings.

Why it was written

After a serious incident, organisations may move too quickly from **"something serious has happened"** to **"this is trauma"** and then offer counselling or specialist trauma treatment. A serious incident is the event. A crisis is the disruption it causes to safety, functioning or everyday life. A trauma-related condition is a mental-health condition identified through appropriate clinical assessment.

The initial organisational response should therefore start by establishing what has changed, what is unsafe, what the person cannot currently do safely or reliably, and what practical action is needed—not by presuming PTSD or automatically arranging counselling or trauma treatment [14,20,28,29,35,42,74,75].

KEY DISTINCTIONS

Serious incident	**What happened — the event itself** — for example a sudden death or suicide; serious injury or accident; assault, abuse or safeguarding incident; major medical or patient-safety incident; transport, workplace or industrial accident; fire, explosion or hazardous-material release; public disorder, terrorism or armed conflict; abduction or missing-person incident; flood or other disaster; and many other events involving serious harm, danger, loss or major disruption.
Crisis	**What has become unsafe, disrupted or difficult because of the incident** — for example difficulty working or carrying out a duty safely**;** severe sleep loss or physical-health problems; difficulty thinking clearly, concentrating or making decisions; difficulty travelling, returning to a particular place or using a usual route; difficulty caring for children or others; disruption to relationships, housing, finances or essential practical arrangements; loss of normal routines or support; and many other difficulties affecting safety, functioning or everyday life.
Trauma-related conditions	A trauma-related mental-health condition identified through assessment. **A serious incident or crisis does not automatically mean PTSD, CPTSD or another trauma-related condition.**

What is the crisis stabilisation and return response (CS-Return)?

The crisis stabilisation and return response (CS-Return) is one example of a qualified clinical early response: a brief, structured, clinician-delivered response—normally one to four sessions—that addresses what a serious incident has disrupted and supports safe continuation, adaptation or return to work and everyday life, while coordinating other help where needed.

How to use this briefing

Part I explains what managers and commissioners should do. Part II explains the evidence and professional reasoning. Appendix A provides the minimum commissioning specification.

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PART I | MANAGER AND COMMISSIONER ACTION

1. What managers check first and what support is needed

After a serious incident, do not begin by assuming that the person is traumatised or needs counselling or trauma treatment. Begin by checking what the incident has changed. Can the person work, travel, sleep, think clearly, care for others and manage everyday responsibilities?

START HERE: CURRENT-IMPACT CHECK

What has changed because of the incident? What problems are happening now? What is the person struggling to do? What needs to happen today?

In this briefing, this practical organisational check is called current-impact triage. It helps decide what support is needed and in what order; it is not clinical triage, clinical formulation or diagnosis. Clinical assessment and triage are undertaken by the qualified professional when a clinical early response is activated. Support may include ordinary organisational support, a qualified clinical early response (e.g. CS-Return), urgent medical, psychiatric or safeguarding action, and separate specialist care. A serious incident or strong distress does not by itself mean PTSD or that counselling or trauma-processing therapy—therapy that works directly with traumatic memories—is needed [14,20,28,29,35,42,74,75].

Signs that action may be needed

• The person is struggling with work, travel, caring for others or another responsibility.	• Severe sleep loss, exhaustion, pain or another physical problem is affecting the person.
• Errors, poor concentration, confusion or poor judgement affect duties or decisions.	• Panic, agitation, repeated checking, irritability or inability to switch off.
• Shutdown, numbness, withdrawal, slowed responses or difficulty communicating.	• Avoidance of the exact place, route, duty, person or routine affected.
• Repeated absence, failed return or a later collapse after appearing to cope.	• Risky coping, self-neglect or practical barriers that nobody is arranging.

WHEN TO ACT
Act immediately if there is a serious safety, medical, psychiatric, safeguarding or operational concern. Otherwise, act as soon as problems are significant, interfere with work or everyday life, affect several areas, or are continuing or getting worse. **Do not wait for a diagnosis before taking action, and do not automatically assume that time off work is the only response. Consider safety, current functioning, temporary adjustments and whether continued work, modified duties or time away is appropriate.**

Decide what support is needed

Managers coordinate the organisational response and take immediate safety and practical action. When activated, a qualified clinical early response (e.g. CS-Return) is delivered by appropriately qualified and experienced mental-health professionals who assess current needs and risks and deliver the response.

Support	When to use it	What the manager does
1. Ordinary support	The person can manage work and everyday life, and normal workplace, family or community support is enough.	Start ordinary organisational support immediately and continue as needed.
2. Qualified clinical early response (e.g. CS-Return)	The incident is causing significant problems with sleep, physical health, thinking, travel, work, caring responsibilities or everyday life, and ordinary support is not enough.	Activate an appropriately qualified and experienced mental-health professional who can assess, stabilise, support safe continuation, adaptation or return to work and everyday life, arrange other help and review what happens next.
3. Urgent medical, psychiatric, emergency or safeguarding action	There is immediate risk to life or safety, severe physical or mental-health deterioration, self-harm or suicide risk, psychosis, severe confusion, intoxication, abuse, safeguarding concern or serious operational danger.	Use the appropriate emergency, medical, psychiatric or safeguarding route immediately. Once the immediate danger is dealt with, begin or continue a qualified clinical early response (e.g. CS-Return) if the incident is still causing problems with work or everyday life.
4. Additional or specialist care	The incident has triggered or worsened an existing condition, or the professional identifies a need for additional or specialist care.	Arrange the additional or specialist care. Continue the qualified clinical early response (e.g. CS-Return) if problems caused by the incident still need help.

MORE THAN ONE TYPE OF SUPPORT MAY BE NEEDED
Use the check above to decide what support is needed and in what order. Ordinary support starts immediately. Urgent action is never delayed. If ordinary support is not enough, begin a qualified clinical early response (e.g. CS-Return); add specialist care where needed. Name who will do each action, by when, and when it will be reviewed.

If the person already had mental-health difficulties or other health or support needs

A person may already have **mental-health difficulties (diagnosed or not), a physical-health condition, disability or other support need**. The incident may make existing difficulties worse or create new ones. *Managers should still focus on what has changed because of this incident, what problems are happening now, and what help or change is needed.*

When qualified clinical early response is used

A qualified clinical early response such as CS-Return is particularly suited to early use and should begin as soon as additional structured support is needed, including while the crisis is still ongoing. In this briefing, the first days to about six weeks after a serious incident are the main early-response window, although the response can also begin later if crisis-related disruption continues, returns or becomes apparent only after some time. Starting within this early window does not mean that support must end within six weeks. CS-Return normally comprises one to four sessions, which may be spaced according to need, and support may therefore continue over several months where functioning, safe continuation, adaptation or return, unresolved problems or handover still need review.

2. What a qualified clinical early response (e.g. CS-Return) must actually do

PLAIN DEFINITION
CS-Return is one brief qualified clinical early response—normally one to four sessions—for people whose sleep, physical health, thinking, travel, work, caring responsibilities or everyday life have been affected by a serious incident. It addresses the problems happening now and supports safe continuation, adaptation or return to the work, journey, place, relationship, responsibility or routine affected. It is delivered by appropriately qualified and experienced mental-health professionals who can assess needs and risks, stabilise, coordinate other help and review what happens next.

What the provider must do	What this means in practice	What the manager should see
1. Assess current impact, risk and priorities	Clinically assess and triage what has changed, current risk, what is unsafe or disrupted, what the person is struggling to do and which response is needed now.	A clear plan for what help is needed and what happens first.
2. Stabilise safety and functioning	Help restore enough safety, regulation and stability for day-to-day functioning—for example through body-focused/non-narrative methods, self-regulation, reliable support from others or temporary changes to routines and surroundings.	The problem is improving, or it is clear what still needs help.
3. Support safe continuation, adaptation or return	Put proactive support around the personal and professional relationships involved, and help the person safely continue, adapt or return to the exact duty, journey, place, relationship, responsibility or routine affected. This may include coaching, facilitated conversations, temporary changes or gradual re-engagement.	It is clear what the person is continuing, adapting or returning to, what changes are needed and when these will be reviewed.
4. Coordinate relational, practical, organisational and multi-agency action	Address relational and practical barriers and coordinate workplace, occupational-health, medical, family, safeguarding, housing, financial, legal, insurer or other action needed.	Each action has a named person, deadline and review date.
5. Review what changed in real life	Review what improved, what did not, which agreed actions happened and what still needs help in work and everyday life.	What has improved and what still needs help is clear.
6. Re-assess and decide next steps	Use the review to re-assess and act: continue or adjust for a defined purpose, agree further actions, close with a clear plan, provide written recommendations where needed, or arrange and hand over to other care.	The next step, reason, responsible person and any handover are clear.

THE SIX FUNCTIONS WORK TOGETHER
They are not six separate steps or sessions. Assessment identifies what needs action; stabilisation, safe continuation/adaptation/return and coordination work together according to need; real-life change is then reviewed and used to decide the next step. If further support is required, that learning informs the next cycle.

Stabilisation means helping the person regain enough regulation and stability to manage the problem affecting them now—for example severe sleep loss, difficulty travelling or concentrating, panic before a shift or difficulty caring for children. In this briefing, functional co-regulation means a named person or service provides calm, practical support with that problem, agrees what will be done and checks whether it helped [7,9–11,18,19,21,33,36,39,41,43,45,47–49,67].

Commission the whole response—not just therapy or psychological support. Managers need to know what will be done, who is responsible and how real-life change will be reviewed.

3. What managers remain responsible for

Managers are not therapists. They are responsible for immediate safety and practical action, deciding what support to activate, making or authorising workplace changes, naming who will do each action and checking that the plan is working. The professional delivering the qualified clinical early response assesses needs and risks and makes professional decisions within their role; managers remain responsible for the organisation's actions.

Managers must	Managers must not
Check for immediate risks and whether the person can manage work, travel, caring responsibilities and normal routines.	Diagnose PTSD or assume that visible distress means a mental-health disorder.
Ask only what is needed to understand what is happening now and decide what help or action is needed.	Ask for the full incident story, trauma history or emotional detail without a clear reason.
Give clear information, practical help, temporary changes and one named organisational contact.	Assume that listening, screening, signposting or making a referral means the crisis has been dealt with.
Activate a provider that can deliver the whole qualified clinical early response.	Assume that any EAP, counsellor, peer programme or person calling themselves a "trauma specialist" can provide the whole response.
Help the person continue safely, adapt or return to work and everyday life, using temporary changes where needed.	Automatically take the person away from work or normal routines, or expect therapy to deal with everything.
Share only what is needed and record who will do each action and when it will be reviewed.	Request therapy content or leave practical actions without a named person or review date.

DO NOT MAKE DETAILED RETELLING THE PRICE OF HELP
Before asking, recording or sharing details of the incident, ask: Why do I need this? What decision will it change? Who needs to know? Could we act with less detail? This does not prevent necessary medical, safeguarding, legal or clinical assessment [11].

4. Do not buy a label—check what the service actually provides

Services sold as “trauma support”, “critical-incident support” or “psychological support” may sound like a complete response when they provide only one part of it. Counselling, EAP, peer support, Mental Health First Aid, TRiM, CISD, screening and referral all have different purposes. Ask what the provider will actually do, what it will not do, and who will deal with anything left out. Do not assume a complete qualified clinical early response is included unless the contract clearly covers all six functions described in this briefing.

Each of these may have a legitimate role, but none should be assumed to provide the complete crisis response unless the commissioned service is responsible for all six functions described in this briefing.

Service / approach	What it actually does	Which of the six functions does it deliver as standard?
Counselling / EAP counselling	Emotional support, talking therapy and referral for an identified need.	None of the six functions as defined in this briefing. A particular service may add some functions, but counselling itself does not provide them.
Peer support	Connection, shared experience, listening and encouragement.	None. Peer support is not clinical triage, active stabilisation, return intervention, accountable coordination, functional review or clinical re-assessment.
Mental Health First Aid (MHFA)	Recognising possible mental-health difficulty, starting a conversation and encouraging appropriate help-seeking.	None. Recognition is not Function 1 clinical assessment/triage, and MHFA does not deliver Functions 2–6.
Trauma Risk Management (TRiM)	Peer-based identification/monitoring of reactions and encouragement to seek help where indicated.	None. Monitoring is not Function 5 real-life clinical review, and TRiM does not deliver the other five clinical functions.
Critical Incident Stress Management (CISM)	A broad critical-incident support framework, not one standard intervention. What is actually delivered varies between programmes and practitioners.	No fixed number can be assumed from the CISM label alone. Depending on the programme and practitioner, CISM may overlap with some of the functions needed, but commissioners must verify exactly what is provided. It should not be assumed to deliver all six functions.
Critical Incident Stress Debriefing (CISD)	A structured seven-phase group discussion.	None of the six functions as defined in this briefing.
Psychological First Aid (PFA)	Early humane support: safety-oriented contact, practical assistance, information, coping support, connection and access to services.	None of the six complete clinical functions. It overlaps with some activities around safety/practical help, but PFA is not a qualified clinical intervention and does not itself deliver any of the six functions in their full defined form.
Screening / fitness assessment	Identifies symptoms, possible needs, concerns or fitness for a role/duty.	None as a complete function. It may provide information relevant to Function 1, but it does not deliver Function 1, because Function 1 also requires clinical triage/formulation and deciding the appropriate response.
Signposting / referral	Connects or directs the person to another service.	None. Referral is not coordination, because Function 4 requires responsibility for arranging and coordinating action; it is not Function 6 either because Function 6 requires clinical re-assessment and accountable transition/handover.
Specialist psychological treatment	Treats an assessed mental-health condition using an indicated clinical intervention.	No fixed number. Depending on the actual treatment service it may also deliver Function 1 and/or Function 2, but those functions are not guaranteed simply because the service provides specialist treatment. Functions 3 and 4 in particular are usually separate unless explicitly commissioned.
Complete qualified clinical early response (e.g. CS-Return)	Addresses current crisis-related disruption through an integrated clinician-delivered response.	All six functions.

Example: why a counselling, therapy or other support contract is not the same as a qualified clinical early response (e.g. CS-Return)

Counselling, specialist trauma treatment, EAP counselling, peer support, MHFA, TRiM, CISD and PFA are used here as common examples of single-support approaches. They may each have a legitimate role, but none should be assumed to provide all six functions unless these are explicitly included.

Counselling, therapy or other support contract	Qualified clinical early response (e.g. CS-Return)
Rapid appointments and changes at short notice are not automatically included.	Sessions are flexible and can be arranged or changed at short notice as needs change.
Contact length and frequency are rigid, so the client has to fit around the therapist rather than support adapting to changing crisis needs.	Sessions may be shorter or longer depending on what needs to be done.
Does not automatically include workplace changes, practical help or support to continue or return to duties and everyday life.	Includes practical help and support to continue or return to duties and everyday life where needed.
Focuses on its specific purpose: emotional support, recognising difficulty, peer monitoring, debriefing, information or connection—without aiming for active changes.	The focus is what the incident has changed now and what help or action is needed for work and everyday life.
Does not include responsibility for coordinating action across people and services.	With the person's agreement, the provider coordinates the work and may also work with managers, occupational health, medical services, family or other services.
May be brief or longer-term according to the therapy or programme model; duration alone does not make it a complete crisis response.	Normally one to four sessions, with an exceptional fifth for transition or handover only. Sessions may be spaced according to need. Each session is a complete action-and-review cycle: triage what needs help, act, review what changed in real life and agree what happens next.
Includes only monthly supervision meetings, which are not enough for crisis work.	A case supervisor is available throughout the response, including before and after each session, with every session reviewed.
Progress may be judged by symptoms, therapeutic goals, knowledge, confidence, help-seeking, peer monitoring or other programme-specific outcomes.	Progress is judged by real-life functioning and whether agreed actions actually happened.

The response must be flexible because the incident may disrupt sleep, travel, shifts, work or family life. A missed or changed session may be part of these problems, not unwillingness to engage. Each session is a complete action-and-review cycle: triage what needs help, act, review what changed in real life and agree what happens next. A counsellor or other mental-health professional needs additional training and supervised practice to deliver the complete qualified clinical early response. A professional title or qualification alone does not demonstrate competence across all six functions.

A SUPPORT APPROACH MAY BE PART OF THE ANSWER WITHOUT BEING THE WHOLE CRISIS RESPONSE
Counselling, specialist trauma treatment, peer support, MHFA, TRiM, CISM/CISD, PFA and other approaches may each have a legitimate role. The question for commissioners is whether the commissioned response actually provides all six required functions and maintains responsibility for what happens next.

What the evidence means for managers

The evidence does not support automatically offering counselling, CBT or specialist trauma treatment to everyone after a serious incident. Nor should any single support approach—such as EAP counselling, peer support, MHFA, TRiM, CISD or PFA—be assumed to provide the complete crisis response. Screening, fitness assessment, signposting and referral may also be necessary processes, but do not themselves constitute the response. Benefits from early trauma-focused CBT are mainly seen in people with acute stress disorder or significant early symptoms, while psychological debriefing does not prevent PTSD and may worsen outcomes for some people [35,46,74–77]. Therapy can be useful, but a serious incident or visible distress alone is not enough reason to automatically offer counselling or specialist trauma treatment.

A workplace-specific systematic review found that most evidence was of poor quality, did not establish clear superiority of any specific post-incident intervention, and identified some negative outcomes associated with generic debriefing [93].

PRACTICAL CONCLUSION
Do not automatically offer counselling or specialist trauma treatment after a serious incident, or assume that EAP counselling, TRiM, Mental Health First Aid, CISM/CISD, screening, signposting or referral provides a complete crisis response. Start with what has changed now: safety, physical needs, practical problems, available help and support, and what the person is struggling to do at work or in everyday life [19,34,42,45,47–49,67–69].

5. What commissioners need in place before an incident

Before an incident, commissioners should make sure the contract covers a complete qualified clinical early response, with all six functions described in this briefing. The contract must make seven things clear:

1. **Who to contact, how quickly they will respond and when the service is available**, including what happens if there is an urgent medical, psychiatric, emergency or safeguarding problem.
2. What the provider will **actually do**—not just the name of the service—and whether it can provide all six functions described in this briefing.
3. **How they will help with the problems caused by the incident** without requiring the person to describe the incident in detail.
4. **Who will arrange any workplace, medical, family or other practical help needed**, who will do each action and when it will be reviewed.
5. **Who stays responsible between sessions and until support is closed or handed over** to another service.
6. **Who will provide the response and whether they are appropriately qualified, experienced and supervised** to assess, stabilise, help the person continue or return to work and everyday life, arrange other help and decide what happens next. The contract should also cover registration, insurance, confidentiality and complaints.
7. **What the provider will report back**—including whether the person is managing work and everyday life better, whether agreed actions happened and whether any handover worked—not symptoms alone.

DO NOT BUY A LABEL OR CERTIFICATE.

Titles such as “trauma specialist”, “trauma therapist”, “trauma practitioner”, “critical-incident practitioner”, “therapist”, “counsellor”, “psychotherapist”, “psychological support provider”, “mental-health practitioner”, “wellbeing practitioner” or “trauma-informed practitioner” may sound professional, but none of these labels is, by itself, protected by law in the UK, and using them does not require registration with a statutory professional regulator or demonstrate professional competence. Do not rely on the title. Check core qualification, statutory registration where applicable or an appropriate accredited register, relevant experience, supervision, insurance and complaints route [80,81]. Then check that the person can actually deliver the functions required by the commissioned response.
In NHS-commissioned healthcare in England, NHS England’s 2026 guidance also sets registration requirements for recognised psychological-profession titles, using statutory or recognised professional registration as applicable [94].

WHO COUNTS AS “APPROPRIATELY QUALIFIED”?
“Qualified clinical early response” describes the response, not a professional title or qualification. Commissioners should require both a recognised core mental-health profession and additional competence in early crisis and trauma response. Examples may include an HCPC-registered clinical or counselling psychologist, a fully accredited psychotherapist or counsellor on an appropriate PSA-accredited register, or another appropriately regulated or registered mental-health professional where this work falls within their professional scope. They should also have relevant post-qualification training, supervised practice and demonstrated competence in early crisis and trauma response, including assessment of current impact and risk, stabilisation, safe continuation/adaptation/return, coordination and recognition of when urgent or specialist care is required. Professional registration alone is not enough. A short course or “trauma” certificate alone is not enough.

Ask every provider these three questions

Question	What the provider should show
1. Who will respond, and are they qualified?	Named staff or roles; recognised core mental-health qualification; current statutory registration or full accreditation on an appropriate PSA-accredited register; and evidence of additional competence in early crisis and trauma response; evidence that they can assess, stabilise, help people continue or return to work and everyday life, manage risk and safeguarding, arrange other help and decide what happens next; as a CTRG commissioning standard, every client session should be reviewed in case-specific supervision by a second experienced professional—not just routine monthly supervision; insurance; and a complaints route.
2. What will you actually do after the incident?	How quickly they respond; how sessions are arranged; whether they provide all six functions of the qualified clinical early response or only part of them; and how they deal with urgent problems, practical help, work and everyday life, review, closure and handover.
3. Who is responsible until support ends or is handed over?	Named provider and organisational leads; who is responsible for each action; how information is shared and protected; what happens if something goes wrong; and who takes responsibility for anything the provider does not deliver.

Make sure the response fits the country, sector and age group

The response must follow the law and local arrangements for emergencies, employment, occupational health, data protection, professional practice and safeguarding. For children and young people, it must also cover age-appropriate communication, consent and confidentiality, family or carer involvement, links with education or children's services, and professionals experienced in working with children [13,52].

Use emergency-planning systems that already exist

Many sectors already plan in advance who will act, who will coordinate and how communication will continue after a serious incident. Examples include aviation family-assistance plans, NHS patient-safety systems, school Psychological First Aid, UK emergency doctrine and JESIP [50–54]. External emergency-response services can also be contracted [55]. Police disaster-victim-identification and NHS family-liaison guidance similarly use named contacts and continuing communication [56–58]. These examples do not show that a complete qualified clinical early response is already being provided; they show that organisations already know how to plan and coordinate a response. Commissioners still need to check exactly what each provider will do.

Four organisational steps after a serious incident	What happens
1. Check	Check what the incident has changed and whether urgent help is needed.
2. Decide	Decide what support is needed now: ordinary organisational support, a qualified clinical early response (e.g. CS-Return), urgent action, specialist care, or a combination.
3. Arrange	Name who will do each workplace, practical, medical or other action and by when.
4. Review	Check what has improved and decide whether to continue, change the plan, close support or arrange other care.

PART II | EVIDENCE AND PROFESSIONAL RATIONALE

6. Why a serious incident is not automatically a mental-health diagnosis

A serious incident is the event. A crisis is what has become unsafe, disrupted or difficult because of it. A trauma-related condition is a mental-health condition identified through proper clinical assessment. After a serious incident, people may be shocked, unable to sleep, highly alert, confused, withdrawn, avoidant or struggling with work and everyday life. These can be common early reactions to a serious event and do not automatically mean that the person has a mental-health disorder. This is not a reason to wait: safety, physical health, coping, practical needs and responsibilities should be addressed immediately, and urgent or clinically indicated assessment must not be delayed [14,20,28,29,35,42].

The missing organisational response

The NICE PTSD guideline and related evidence mainly tell services how to recognise, assess, prevent and treat PTSD. **They do not by themselves provide a complete organisational response** for who will deal with the practical crisis after an incident: who checks what has changed, who arranges practical or workplace action, who helps the person continue or return to everyday life, who stays responsible and who checks whether things have improved [27–30].

The problem is not that organisations have no support. Many already have counselling, EAPs, Mental Health First Aid, TRiM, CISM/CISD, screening, signposting, referral routes and access to mental-health or trauma treatment. The problem is automatically routing people into counselling or trauma treatment, or treating any one of these approaches or processes as if it provides the complete crisis response. Doing this can risk pathologising common early crisis reactions, create unnecessary referrals and move people into mental-health services who may not need treatment [28,29,35,74,75]. This creates avoidable demand in mental-health services that are already under significant pressure [90,91], while the original crisis may remain unmanaged.

A person may therefore be listened to, screened, referred or offered treatment while nobody is dealing with the things actually causing difficulty now: sleep, safety, physical health, concentration, travel, work, caring responsibilities, practical problems or return to everyday life. **A mental-health referral may move the person into another system without managing the crisis that caused the referral.** Where assessment shows that mental-health treatment is needed, it should be provided—but it should not replace stabilisation, practical action, coordination and support to continue or return to everyday life.

THE SYSTEM FAILURE IN PLAIN TERMS
Automatically referring people into counselling or specialist mental-health treatment can pathologise common early crisis reactions, create unnecessary referrals and add avoidable pressure to mental-health services, while the practical crisis itself remains unmanaged.

7. Where the crisis stabilisation and return response (CS-Return) comes from—and what it adds

The principles that inform early response after serious incidents are not new. Across more than 130 years of trauma and crisis practice, different **clinical, crisis and psychosocial traditions** have emphasised safety, stabilisation, coping, resources, functioning, adaptation and reconnection before or alongside specialised treatment [95]. This does not mean that one consistent model of **qualified clinical early response** existed across this period; these are historical antecedents and related traditions that help explain the principles on which contemporary responses can build.

From 1889 onwards, Pierre Janet's work contributed to one of the earliest phase-oriented understandings of post-traumatic difficulties, later described through stabilisation, work with traumatic memories and reintegration or rehabilitation [41,71]. **In 1917**, Thomas Salmon documented First World War forward psychiatric practice, which emphasised prompt intervention, proximity to the person's ordinary role and an expectation of functional recovery [78,79]. **In 1944**, Erich Lindemann's work on acute grief helped develop crisis-intervention thinking concerned with restoring coping and adaptation [72]. **In 1964**, Gerald Caplan developed crisis theory further, emphasising coping, available resources and support during periods of crisis [73]. These historical sources show continuity in important principles; they are not modern evidence of effectiveness or evidence of one continuous early-response model.

Modern early-support approaches continued many of these principles. **The 2006 Psychological First Aid Field Operations Guide** emphasised safety, practical assistance, coping, access to resources and social connection

[19,34,42,45,47–49]. **In 2010, Skills for Psychological Recovery (SPR)** extended this towards managing continuing difficulties, developing coping skills and restoring functioning in the weeks and months after serious events [60]. PFA and SPR are important examples of early support, but they are **not equivalent to a qualified clinical intervention**: PFA can be delivered by trained non-clinical helpers, while SPR is a structured skills-based approach rather than formal mental-health treatment [45,47,49,60,95].

What CS-Return adds is a contemporary qualified clinical configuration of these established principles for situations in which ordinary organisational or psychosocial support is not enough. It brings clinical assessment and triage, active stabilisation, safe continuation, adaptation or return, relational and practical coordination, review of real-life change and clinical re-assessment together within one brief, integrated clinician-delivered response. Its proposed contribution is therefore not the invention of the individual principles, but their integration within an accountable qualified clinical early-response intervention. Trauma processing is not part of CS-Return and is provided separately where clinically indicated [64,95].

The contemporary CS-Return framework developed through Complex Trauma Institute training and practice from 2019, was delivered and refined through the Complex Trauma Therapists Network from 2020, and from 2022 to 2025 was also taught to Ukrainian psychologists under the working title Crisis and Trauma Stabilisation Framework. It was codified in the CTI clinical handbook in 2025 under the earlier Crisis & Trauma Stabilisation title [64,95]. This briefing sets out its wider organisational and commissioning application.

8. Why stabilisation and return to everyday life begin together

Stabilisation and return are recovery functions in their own right. Stabilisation is not simply calming someone down, reducing distress or preparing them for therapy. It is about helping the person maintain or regain the functioning disrupted by the crisis. Return is not aftercare left until treatment ends.

From the first session, support should therefore focus on what the crisis has disrupted and what the person is struggling to do now. This may include sleeping, thinking clearly, travelling, entering a particular place, working a shift, attending school or university, caring for children or others, managing family responsibilities, maintaining relationships or continuing an ordinary routine.

Support should identify what will help the person continue safely, adapt where needed or return as early as appropriate. This may involve practical help, temporary changes, support from other people or services, and gradual steps back into the exact situation affected [18,21,33,36,67–69].

Return here means more than return to work. It includes work, education, family and caring responsibilities, relationships, travel, community participation and ordinary routines. Return may need to be gradual or supported by temporary changes and **must never mean forcing someone back before it is safe.**

Psychological First Aid and Skills for Psychological Recovery similarly connect coping with practical action, resources, functioning and reconnection rather than focusing on symptoms alone [19,45,47–49,59–61]. **Stabilisation and return are recovery functions in their own right—not simply preparation for therapy and aftercare following treatment.** Specialist treatment can be added when assessment shows that it is needed.

Why return matters

Return shows whether stabilisation is working outside the support session.

A person may feel calmer during a conversation but still be unable to sleep properly, travel the route, enter the classroom, work the shift, care for children, make decisions or resume the routine affected. Feeling better during a support session therefore does not necessarily mean that the crisis has been resolved.

A planned and reviewed continuation, adaptation or return shows whether the person is actually functioning better in everyday life. It helps restore participation and confidence, prevents support ending simply because distress has reduced, and helps decide whether the response can close, needs to continue or change, or whether additional or specialist care is needed [18,21,33,36,67–69].

What is not consistently available

Elements of this response already exist across current services. Specialist trauma services may provide stabilisation; critical-incident services may provide rapid support; occupational and workplace services may support functioning and return; and other services may provide practical help, coordination or specialist treatment [82–88]. **What is not consistently available is one response that brings all six functions together from the beginning of the crisis.**

Much established stabilisation is provided inside specialist trauma, abuse, Complex Trauma/CPTSD or longer-term mental-health services. These services are important, but they may require a diagnosis, referral, local eligibility or regular attendance and are not always designed for immediate activation after a new serious incident. Critical-incident services also exist, but their public descriptions do not always show responsibility for practical action, continuation or return, coordination, continuity and review of real-life functioning [82–88].

CTI implementation example. The Complex Trauma Institute (CTI), which convenes the Crisis & Trauma Recovery Group, currently provides a brief crisis stabilisation and return response (CS-Return) based on the functions described in this briefing [64]. This is included transparently as an implementation example, not as independent evidence for the effectiveness of the model.

POLICY WARNING – STOP CHASING THE ECHO OF THE CRISIS
Organisations may repeatedly pay to treat the later psychological echo of a serious incident while failing to deal with the crisis when it is happening—for example severe sleep problems, practical difficulties, workplace disruption or difficulty continuing or returning to everyday life.

The Crisis & Trauma Recovery Group calls on statutory, charitable and independent mental-health and crisis-support providers to ensure that serious-incident provision does not focus only on later psychological effects, but includes a timely qualified clinical early response (e.g. CS-Return) when ordinary organisational or psychosocial support is not enough. A complete response should:

- allow an organisation to activate support without first requiring a PTSD diagnosis or detailed trauma history;
- identify the exact work or everyday-life problem caused by the incident and offer rapid, flexible sessions;
- arrange workplace, family, medical and multi-agency actions, with a named person responsible for each action;
- support safe continuation, adaptation or return to duties and ordinary routines from the first session; and
- review progress, maintain continuity and arrange separate clinical treatment where it is needed.

The past incident cannot be changed, although its continuing psychological effects can be treated. But the crisis it created may also involve practical, relational, workplace and organisational problems that can be acted on now. The policy shift is simple: provide timely stabilisation and return support while the crisis is happening, and add psychological treatment where it is clinically needed.

9. Why detailed retelling is not required

People should not have to repeatedly describe a serious incident in order to receive help. In this briefing, the Principle of Necessity for Trauma (PNT) means asking, recording or sharing incident and trauma details only when they are needed for safety, a practical decision, legal or safeguarding duties, an agreed intervention or a necessary professional decision [11]. This applies to referral forms, assessments, handovers, management reports, records and supervision—not only therapy sessions.

Before asking, recording or sharing details, ask:
Why is this necessary?
What decision will it change?
Who needs it?
Could the same action be taken with less detail?

Parts of this principle are already reflected in existing practice, although not necessarily under the name PNT. For example, Psychological First Aid does not require a detailed discussion of the event and is different from psychological debriefing [45,47,49,59]. Other publications describe non-narrative and embodied work with trauma-related memories and nightmares [12,23–25]. These are examples of minimising unnecessary disclosure; they do not mean that PFA or any other single method provides the whole crisis stabilisation and return response (CS-Return). Necessary medical, safeguarding, legal and clinical assessment must still take place.

10. Complex Trauma/CPTSD and specialist care

In this briefing, Complex Trauma/CPTSD is used as shorthand for complex trauma-related presentations; CPTSD refers specifically to the ICD-11 diagnosis. It is usually linked to repeated, prolonged or interpersonal trauma and can affect emotional regulation, identity, trust, relationships, behaviour, physical responses and everyday life. **Processing one memory may help one defined difficulty, but does not automatically restore regulation, trust, relationships, identity, participation, roles or everyday functioning** [6,7,9,10,18,21,33,36]. Case and practice literature also shows that presentations and treatment needs vary [8,37].

THE SECOND SYSTEM FAILURE
The same pathway error can occur in complex-trauma care: trauma processing can become the main part of the pathway while stabilisation, relationships, functioning, participation and return to ordinary life remain underdeveloped. The aim is not to reject processing, but to keep it proportionate to the clinical need.

A new serious incident may reactivate or worsen existing Complex Trauma/CPTSD. The first task is still to address what the current crisis has disrupted: physical health, sleep, regulation, work and everyday responsibilities, practical needs and immediate risks—not to automatically begin processing historical trauma. The crisis stabilisation and return response (CS-Return) can continue while additional or specialist care is arranged where assessment identifies a clinical need.

When separate targeted or specialist care is indicated

Therapeutic work involving deliberate recall or processing of potentially traumatic memories is **not one of the six crisis stabilisation and return response (CS-Return) functions**. It should occur only where assessment identifies a clinical need. Urgent or clinically indicated treatment must not be delayed in order to complete the crisis stabilisation and return response (CS-Return) [27–29,35,38,46].

TRAUMA PROCESSING IS SEPARATE AND SELECTIVE
The crisis stabilisation and return response (CS-Return) must not become a pathway whose endpoint is trauma processing. Processing is a separate clinical option for an assessed need—not the automatic next stage after a serious incident or after stabilisation.

Use proportionate, low-disclosure treatment where clinically suitable

A serious incident or crisis-related distress should not automatically lead to EMDR, trauma-focused CBT or another longer trauma-processing programme. During the first month, the organisation should still manage the crisis through stabilisation, practical action, support for functioning and review. Trauma-focused CBT may begin within the first month for adults with acute stress disorder or clinically important PTSD symptoms, and other specialist treatment should begin whenever competent assessment identifies a clear clinical need [27–29,35,38].

Where assessment identifies a clearly defined trauma-linked problem—such as an intrusive memory, image, nightmare, flashback or trigger—and processing is clinically appropriate, use the most proportionate evidence-supported intervention. Where a very brief, low-disclosure method is suitable, consider it before automatically moving to a longer trauma-processing programme.

This does not mean that brief treatment must always be tried first. Where broader PTSD, Complex Trauma/CPTSD, severe dissociation, continuing threat, significant risk or other complexity requires longer, phased, psychiatric or multidisciplinary care, that treatment should begin without delay [27–29,35,38].

The Principle of Necessity for Trauma still applies during treatment: ask for trauma detail only where it is needed for the intervention, safety, legal or safeguarding duties, or another necessary professional decision [11].

Rewind as one evidence-supported example of brief, low-disclosure processing

The Rewind Technique is a brief, usually one-to-one, low-disclosure method for processing trauma-related memories [1–3,17]. It is included here because it shows that a clearly defined trauma-linked problem can sometimes be treated in one or a few sessions rather than automatically requiring a longer trauma-processing programme.

Published evidence includes a multisite pilot, qualitative research, an exploratory randomised controlled trial and other published applications [1–3,17,40]. The RCT allowed up to three Rewind sessions and found significantly lower clinician-rated PTSD symptoms than the control condition at eight weeks, with a large effect size (Cohen's d = 1.05), maintained at 16 weeks [2,3]. A 2025 NHS study of 10 UK military veterans also reported significant improvements in PTSD, depression and insomnia after a mean of three sessions [89].

Rewind is not part of the crisis stabilisation and return response (CS-Return) and should not be offered automatically. It is one example of why, where trauma processing is clinically needed, a brief evidence-supported option may be considered before automatically moving to a longer programme. Longer or more specialist treatment should begin without delay where clinically needed.

CORE CLINICAL PRINCIPLE
Where a clearly defined trauma-linked problem may be addressed in one or a few sessions, do not automatically default to a longer trauma-processing programme such as EMDR or trauma-focused CBT. Consider the most proportionate evidence-supported option, including a brief, low-disclosure method where clinically suitable. Longer or specialist treatment should begin without delay where clinically needed.

11. How commissioners check competence and quality

Do not rely on a title such as “trauma specialist”. For CS-Return or another qualified clinical early response, commissioners should check that appropriately qualified, experienced, insured and accountable mental-health professionals can assess current impact and risk, stabilise functioning, support safe continuation, adaptation or return, coordinate action and recognise when specialist care is needed [62,63].

As a CTRG commissioning standard, every client session should be reviewed in case-specific supervision by a second experienced professional—not just through routine monthly supervision.

Check that all six functions are actually delivered

The six commissioning functions used in this briefing correspond to the six practitioner competencies described in the clinical CS-Return framework [95].

For CS-Return specifically, practitioners must also be appropriately qualified mental-health professionals practising within scope and additionally trained across all six CS-Return practitioner competencies [95].

Ask the provider to show how it will:

1. assess current impact, risk and priorities;
2. stabilise safety and functioning and check whether the help provided worked;
3. support safe continuation, adaptation or return to the exact role or routine affected;
4. coordinate relational, practical, organisational and multi-agency action with clear responsibility;
5. review what changed in real life—not symptoms alone; and
6. re-assess and decide next steps, including continuation, adjustment, closure or handover.

The service must also be able to respond flexibly, manage urgent concerns, maintain responsibility between sessions, protect confidentiality and avoid unnecessary detailed retelling.

Check what actually changed

Check real-life outcomes, not only sessions, referrals or symptom scores: whether urgent needs were acted on, agreed actions happened, functioning improved, safe continuation, adaptation or return occurred, and handovers worked.

If the provider cannot show how all six functions were delivered and whether they made a real-life difference, commissioners should not assume they are buying the whole qualified clinical early response.

12. How this briefing was developed

The Crisis & Trauma Recovery Group, a cross-sector expert group and think tank convened by the Complex Trauma Institute, developed this briefing through multidisciplinary consultation and review. The group used targeted searches of peer-reviewed research, systematic reviews, national and international guidance, historical sources and current service information. Priority was given to systematic reviews, controlled studies, official guidance and primary historical sources.

Service webpages and internal documents are used only to describe current provision or emerging implementation [64,82–88]. The peer-reviewed manuscript currently in the publication process [32] is clearly identified and is not treated as established published evidence. Searches and service checks were updated to August 2026. This is an evidence-informed policy and practice briefing, not a systematic review or clinical guideline. No external funding was received.

The six practitioner competencies—translated in this briefing into six commissioning functions—together with the one-to-four-session format and supervision model are CTI implementation specifications, codified in the CTI clinical handbook [64,95]. CTRG reviewed the framework and developed the wider cross-sector organisational and commissioning recommendations in this briefing.

Transparency and interests: CTRG is convened by CTI, which also provides a crisis stabilisation and return response (CS-Return). CTI is included as one implementation example and not as independent evidence for effectiveness. CTI also provides paid training in the Rewind Technique. Rewind is included in this briefing only as one example of a brief, low-disclosure treatment option; it is not part of CS-Return or a required component of the response.

CONCLUSION

The central commissioning error is that a crisis is too often treated as evidence of a trauma-related condition. Organisations may then commission counselling, EAPs, trauma treatment, peer programmes, MHFA, TRiM, CISM/CISD, screening, fitness assessment, signposting or referral—**approaches and processes with different purposes—while the crisis itself is left without a coordinated response.**

Some identify concerns, monitor reactions, encourage help-seeking, refer or treat the **psychological echo of the crisis**. **But they do not, on their own, assess and manage what the crisis has disrupted:** stabilise functioning, coordinate practical action, support continuation or return, maintain responsibility and review what actually changed.

The policy shift is simple: commission a crisis response for the crisis. Where additional structured support is needed, provide a qualified clinical early response (e.g. CS-Return), and add targeted or specialist treatment where assessment identifies a clinical need.

POLICY SHIFT
Do not treat a crisis as proof of a trauma-related condition. Commission a response to what the incident has disrupted: stabilise functioning, support safe continuation, adaptation or return, coordinate practical action and add specialist treatment where it is clinically needed.

APPENDIX A. MINIMUM COMMISSIONING SPECIFICATION

This appendix translates the recommendations into a minimum commissioning specification for designing, buying or reviewing the response.

Use this checklist when designing, buying or reviewing a qualified clinical early response. CS-Return is the integrated implementation example used in this briefing. It does not mean that everyone affected by an incident should be referred. It means that the whole response must be available and that no single therapy, support programme, training package, assessment, screening process or referral route should be treated as the complete crisis response on its own.

What the contract must require	What this means in practice
1. Complete response	The contract must cover all six functions of a complete qualified clinical early response. CS-Return is one integrated example. It must be clear who provides each part.
2. Preparedness and rapid access	A named organisational lead and provider; clear rules for when to use the service; response times; operating hours; and links to urgent and specialist services.
3. Access based on current need	Support is offered because the incident has caused problems that need help now—not simply because someone was exposed. Detailed retelling is not required.
4. Immediate urgent redirection	Urgent medical, mental-health, safeguarding or operational problems are identified and acted on immediately.
5. Brief, focused and reviewable delivery	The response should remain focused on current need, action and real-life review. In CS-Return, each session is a complete action-and-review cycle: triage what needs help, act, review what changed in real life and agree what happens next.
6. Proven competence	Relevant mental-health qualification, scope of practice and supervised experience, with evidence that the professional can assess, stabilise, support safe continuation, adaptation or return to work and everyday life, coordinate other help, manage risk and safeguarding, and decide what happens next, alongside indemnity and professional governance [62,63,80,81]. As a CTRG commissioning standard, every client session should be reviewed in case-specific supervision by a second experienced professional—not just through routine monthly supervision.
7. Coordination and continuity	Every workplace, medical, occupational-health, family, safeguarding, legal, financial or insurer action has a named person responsible and a review date.
8. Safe continuation, adaptation or return	Support is linked to the exact duty, journey, setting, relationship, family responsibility or routine affected and supports safe continuation, adaptation or return as early as appropriate, using temporary or gradual changes where needed.
9. Low-disclosure information practice	Forms, assessments, handovers and reports ask only for information needed for safety, action or a necessary professional decision [11].
10. Separate and proportionate specialist treatment	Trauma processing is separate from the crisis stabilisation and return response (CS-Return) and is used only where assessment identifies a clinical need. Where processing is needed, use the most proportionate evidence-supported option; a brief, low-disclosure intervention may be considered where clinically suitable, but it is not a required step before longer or specialist care.
11. Accessibility and sector fit	Language, culture, disability, neurodivergence, sensory needs, children, continuing threat and sector-specific risks are planned for.
12. Useful outcomes	Reports show whether urgent risks were managed, people could continue safely, adapt or return to the exact work duty, journey, place, family responsibility or ordinary routine affected, agreed actions and handovers happened, and functioning improved in real life—not symptoms alone.

Minimum crisis stabilisation and return response (CS-Return) record for commissioners

Area	What must be recorded	Commissioner check
1. Activation	Date, referral route, reason and response time.	Did support start when it was needed?
2. Current-impact triage	What changed, what problems are happening now, any urgent needs and what support was agreed.	Was support based on what was happening now rather than exposure alone?
3. Urgent action	Any medical, psychiatric, safeguarding or operational concern and the action taken.	Was urgent action taken immediately?
4. Stabilisation and return	Help provided, exact role or routine affected, temporary changes and review date.	Did support address the actual problem and help the person continue or return?
5. Practical coordination	Required workplace, family, medical, occupational-health, housing, financial, legal or agency actions.	Did every action have a named person, deadline and review date?
6. Real-life review	Changes in sleep, concentration, travel, work, caring responsibilities and everyday life.	Were changes in everyday life reviewed—not symptoms alone?
7. Next professional decision	Continue, change the plan, close, urgently redirect or arrange separate care, with the reason.	Did each session end with a clear next step?
8. Closure and quality	Handover, remaining actions, warning signs, accessibility, experience, complaints and adverse events.	Was responsibility clearly handed over and was learning recorded?

CAN THE RESPONSE PASS THIS TEST?
Can a manager immediately contact a named provider or coordinated service with appropriately qualified and experienced professionals who can assess the current problem, provide the whole crisis stabilisation and return response (CS-Return), keep support coordinated between sessions and decide what happens next? Is every action assigned to a named person with a review date?

APPENDIX B. KEY TERMS AND ABBREVIATIONS

Term	Meaning for managers and commissioners
Qualified clinical early response	Clinician-delivered early support used when ordinary organisational or psychosocial support is not enough, focused on current disruption, stabilisation, functioning, coordination and deciding what happens next. CS-Return is one integrated example.
Current crisis-related disruption	What the serious incident has changed now and what needs help—for example sleep, physical health, concentration, travel, work, caring responsibilities, routines or practical problems.
Stabilisation	Helping the person deal with what the crisis has disrupted so they can continue functioning where possible, or regain functioning where it has been disrupted.
Continuation, adaptation or return to roles and routines	Practical support to help the person continue safely, adapt or return to the exact work duty, journey, place, family responsibility or everyday routine affected by the incident, using temporary changes where needed.
Practical help and coordination	Making sure any workplace, occupational-health, medical, family, safeguarding, legal, financial, insurer or other help needed after the incident is actually arranged.
Functional co-regulation	A named person or service provides calm, practical support with the exact problem caused by the incident—for example before a shift, during travel or when returning to a difficult place—agrees what will be done and checks whether it helped.
Trauma processing	Therapy that deliberately works with traumatic memories, emotions or meanings. It is separate from the crisis stabilisation and return response (CS-Return) and is used only where there is a clinical need.
Integration / continuation, adaptation or return to ordinary life	Helping the person continue safely, adapt or return to work, travel, family responsibilities, relationships, routines and community life—not simply reducing symptoms.
Low-disclosure support (help without detailed retelling)	Providing help without requiring the person to describe the serious incident in detail. Ask only for information needed for safety, practical action, legal or safeguarding duties, or a necessary professional decision.

Abbreviations

Abbreviation	Meaning	Abbreviation	Meaning
ASD	acute stress disorder	CISD	critical incident stress debriefing
CISM	critical incident stress management	CPTSD	complex post-traumatic stress disorder
CTI	complex trauma institute	CTRG	crisis & trauma recovery group
EAP	employee assistance programme	EMDR	eye movement desensitisation and reprocessing
MHFA	mental health first aid	NICE	national institute for health and care excellence
PFA	psychological first aid	PNT	principle of necessity for trauma
PTSD	post-traumatic stress disorder	RT	rewind technique
TF-CBT	trauma-focused cognitive behavioural therapy	TRiM	trauma risk management
WHO	world health organization	CS-Return	crisis stabilisation and return response

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