— 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.

Detailed retelling of the incident should not be part of the qualified clinical early response. Ask only for the information needed to assess current impact and risk and decide what action is required. 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 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 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). Detailed retelling of the incident should not be part of this early response.

Numbered references correspond to the full briefing, available via the CTRG website.

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 serious incident.

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 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

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