— CRISIS & TRAUMA RECOVERY GROUP —

THE MISSING EARLY RESPONSE AFTER SERIOUS INCIDENTS

Why counselling and therapy should not be the automatic response

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, the Stabilisation and Return Response should begin before specialist care, alongside appropriate organisational, practical and medical support—not routine counselling or specialist trauma treatment. Urgent medical, psychiatric or safeguarding action must never be delayed [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 detailed retelling 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 THE STABILISATION AND RETURN RESPONSE

Delivered by appropriately qualified and experienced professionals, the Stabilisation and Return Response provides six connected functions:

1 Check current impact (triage)	4 Coordinate practical and multi-agency action
2 Stabilise current functioning	5 Review functioning and real-life change
3 Support continuation or return to roles and routines	6 Continue, adjust or close—or arrange separate targeted or specialist care

The Stabilisation and Return Response has two connected purposes: to stabilise what has become unsafe or disrupted, and to help the person continue or return to the exact duty, journey, place, family responsibility or ordinary routine affected. These begin together. It may include support with sleep, physical health, clear thinking, decision-making, travel, work, caring responsibilities, temporary adjustments and coordinated medical, practical, workplace or family action [7,9–11,18,19,21,33,36,39,41,43,45,47–49,67]. The same stabilisation and return functions apply whether the disruption is a current crisis, the destabilisation of an existing trauma-related condition, or part of 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 a provider able to deliver and coordinate all six Stabilisation and Return Response functions, maintain continuity, support continuation or return from the first contact and review real-life outcomes.

Without a clear commissioning framework, organisations may mistake specific support approaches for a comprehensive early response. Traditional counselling, peer-support programmes, mental health first aid (MHFA), trauma risk management (TRiM), critical incident stress debriefing (CISD), screening, aeromedical or occupational fitness assessment, signposting or referral do not by themselves provide a comprehensive early response [4,5,16,22,26–29,35,44,46,62,63,65,66,67]. These approaches may identify concerns, monitor reactions, encourage help-seeking or assess fitness, but they do not by themselves deliver active stabilisation, coordinate practical and workplace action or support continuation or return to duties and everyday life. Specialist trauma treatment should be commissioned only for an assessed clinical need [27–29,35,46].

CORE MESSAGE Counselling and specialist trauma treatment should not be automatic first responses after serious incidents. Where additional support is needed, begin with the Stabilisation and Return Response, without requiring people to describe serious incidents in detail before receiving help.

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VISUAL OVERVIEW FOR MANAGERS AND COMMISSIONERS

THE MISSING EARLY RESPONSE AFTER SERIOUS INCIDENTS

Why counselling and therapy should not be the automatic response

- 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, unable to sleep, struggling to concentrate 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 that encourages detailed retelling or focuses directly on memories, emotions and meanings may be unhelpful and can be harmful for some people.

WHAT SHOULD HAPPEN FIRST

Where additional structured support is needed, begin with the Stabilisation and Return Response, alongside appropriate organisational, practical and medical support.

USUAL RESPONSE TIMEFRAME

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

Usually relevant from the first day to approximately six weeks, and sometimes up to two months.

HOW THE RESPONSE WORKS

Connected functions — not separate treatment stages.

1 CHECK CURRENT IMPACT (TRIAGE)

Is this about safety, functioning and urgent needs.

2 CONNECTED RESPONSE FUNCTIONS

These functions are addressed together and may overlap.

- **A. STABILISE CURRENT FUNCTIONING** — Restore enough stability for safer day-to-day functioning.
- **B. SUPPORT SAFE RETURN TO ROLES & ROUTINES** — Help the person re-engage safely and gradually.
- **C. COORDINATE PRACTICAL & MULTI-AGENCY ACTION** — Address workplace, medical, family and practical barriers.

3 REVIEW FUNCTIONING

Can the person function more safely and reliably?

Are risk or significant continuing difficulties still present?

4A CONTINUE, ADJUST OR CLOSE

Continue only for a defined short-term purpose. Otherwise, close with a clear plan.

4B ARRANGE SEPARATE TARGETED OR SPECIALIST CARE

Where risk, persistent difficulty, complexity or significant impairment remains, arrange separate assessment or care.

RELEVANT ACROSS CRISIS-EXPOSED SECTORS

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

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