Resilient Responders Best Practices Repository for Module 2

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Resource 1

1. Title of the Best Practice

Practical Guidelines for the population: “How to emotionally recover from fire situations?”

2. Related Training Module

Module 2 - Stress Management Techniques

3. Context and Background

The practical was developed by the Portuguese Psychologists’ Society (Ordem dos Psicólogos Portugueses) in articulation with the Directorate-General of Health (DGS) and the National Authority for Emergency and Civil Protection (ANEPC) in response to the recurring wildfires that have severely affected communities across Portugal. Published nationally in August 2025, the guide builds on lessons learned from previous disasters, particularly the devastating 2017 Pedrógão Grande fires, which highlighted the long-term psychological and social impacts of such crises.

Its purpose is to provide accessible strategies for emotional recovery and stress management after experiencing or witnessing fire-related events, addressing common reactions such as fear, shock, anger, sadness, and a sense of injustice. The target audience is the general population, including children, adolescents, adults, and older adults, ensuring that all age groups have tailored advice to support resilience and well-being. While rooted in the Portuguese context, the guide reflects a broader commitment to promoting community mental health and disaster recovery in societies exposed to climate-related emergencies.

4. Objectives of the Practice

The main objectives of the practice are to support the emotional recovery and stress management of individuals and communities affected by wildfires and to provide accessible, practical strategies that promote resilience and well-being after such traumatic events. Specifically, the guide seeks to:

- Normalise emotional reactions such as shock, fear, sadness, anger, or feelings of injustice, helping people understand that these are common responses to crisis.

- Equip individuals and families with coping strategies to manage stress, rebuild routines, and regain a sense of safety and control after fire-related experiences.
- Encourage community support and solidarity, highlighting the importance of seeking help and staying connected with others during recovery.
- Provide tailored advice across age groups (children, adolescents, adults, and older adults), recognising that different populations have distinct needs and vulnerabilities.
- Promote timely access to psychological support, reducing the risk of long-term mental health problems such as anxiety, depression, or post-traumatic stress.

The problems it aims to address are directly linked to the psychological and social consequences of wildfires, including: emotional distress, disruption of daily life, feelings of insecurity, and potential isolation of vulnerable individuals. By offering clear and practical guidance, the guide helps bridge the gap between immediate crisis response and long-term mental health care, empowering communities to recover more effectively from disaster.

5. Description of the Practice

This guide helps people accept intense emotions as natural; encourage talking (or quiet companionship), reconnecting with others affected, limiting constant media exposure, and restarting simple daily routines (sleep, meals, movement, breaks, leisure). The guide contains stress management techniques, checklists/tips and national/community resources. It teaches brief techniques people can use on their own when flashbacks or spikes of anxiety occur: touch present-moment objects, describe surroundings aloud, sip cold water slowly, listen to favorite music, pet an animal, call a trusted person, or use cold-water/ice-in-hands reset for a few minutes.

It also provides guidance to caregivers stay physically/emotionally available; validate feelings; answer questions simply and truthfully; keep predictable routines (meals/bedtime/school); promote play, time with peers, and small responsibilities that restore agency with children and young people. And targeted strategies for older people like the need to build or activate a daily support network (family, neighbors, social services); quickly restore access to regular medication, glasses, prostheses and appointments; maintain identity and continuity using routines and meaningful tasks; use photos/objects to orient and reminisce.

Finally, it clearly explains what could be some warning signs—persistent loss of interest, problematic substance use, impaired functioning, unrefreshing sleep/nightmares, pervasive avoidance, hyper-alertness, irritability/aggression—especially if they last beyond about one month; escalate care accordingly, giving clear guidance on how to proceed in those circumstances.

6. Outcomes and Impact

There is no publicly available data (e.g., usage statistics, outcomes, satisfaction surveys) regarding this guide. Nor does there appear to be published feedback or evaluation.

7. Lessons Learned and Success Factors

There is no publicly available data (e.g., usage statistics, outcomes, satisfaction surveys) regarding this guide. Nor does there appear to be published feedback or evaluation.

8. Transferability and Adaptability

The Portuguese guide offers a flexible framework that can be adapted to other regions and crises by focusing on universally relevant elements: normalising emotional reactions, promoting coping strategies and routines, tailoring advice to different age groups, monitoring warning signs, and encouraging timely access to professional support. To apply it elsewhere, adaptations should consider local language, cultural values, community structures, and available health systems, replacing national resources (like Portugal's SNS24 hotline) with local equivalents. The approach can also be extended beyond wildfires to other disasters—such as floods, earthquakes, or pandemics—and disseminated through low-cost channels like posters, radio, or mobile apps. The techniques are also valid for other type of natural disasters.

9. Ethical Considerations

There is no publicly available data (e.g., usage statistics, outcomes, satisfaction surveys) regarding this guide. Nor does there appear to be published feedback or evaluation.

10. References

Ordem dos Psicólogos Portugueses. (2025). Como recuperar emocionalmente de situações de incêndio? Guia Prático para a População [PDF]. https://www.ordemdospsicologos.pt/ficheiros/documentos/comorecuperaremocionalmentesituacoesincendio.pdf

Resource 2

1. Title of the Best Practice

Stress First Aid for Firefighters and Emergency Medical Services Personnel - USA

2. Related Training Module

Module 2 - Stress Management Techniques

3. Context and Background

Stress First Aid (SFA) was implemented in the United States as part of the National Fallen Firefighters Foundation's "Everyone Goes Home" program, under Firefighter Life Safety Initiative #13, which emphasizes access to counseling and psychological support for firefighters and their families. The practice was developed in 2013 and funded through the Assistance to Firefighters Fire Prevention & Safety Grant Program by the Department of Homeland Security and the Department of Justice.

SFA originated as a civilian adaptation of the Combat and Operational Stress First Aid (COSFA) model used by the U.S. military, created in collaboration with the National Center for PTSD and the Department of Veterans Affairs. It was designed to address the unique stressors faced by firefighters and Emergency Medical Services (EMS) personnel, such as exposure to traumatic events (e.g., line-of-duty deaths, multi-fatality incidents), cumulative operational stress, and personal life challenges.

The target group includes **firefighters, EMS providers, and their leaders, with a focus on peer-to-peer support within natural work settings**. The geographic setting is primarily fire and EMS departments across the United States, but the model is adaptable for other first responder organizations.

The purpose of SFA is to reduce the risk of stress reactions progressing into severe or chronic conditions, promote recovery, and bridge individuals to higher levels of care when necessary. It provides a flexible, ongoing process rather than a one-time intervention, emphasizing leadership, unit cohesion, and peer support as critical components for resilience and mental health in high-risk professions.

4. Objectives of the Practice

Based on the manual, the practice aims to:

- Continuously monitor stress levels among firefighters and EMS personnel to identify early signs of distress or impairment.
- Prevent the progression of stress reactions into severe or chronic conditions by providing timely, compassionate support.
- Promote recovery and resilience through structured peer support and leadership engagement.
- Bridge individuals to higher levels of care (e.g., behavioral health professionals) when necessary.
- Foster a supportive organizational culture that normalizes seeking help and reduces stigma around mental health.

Natural disasters often lead to intense emotional suffering, disruption of social networks, and a sense of loss and insecurity. Many professionals lack knowledge about coping strategies, which can increase vulnerability to chronic stress, depression, or post-traumatic stress disorder. Furthermore, the breakdown of community structures during disasters can leave people feeling isolated and unsupported. High exposure to traumatic events (e.g., line-of-duty deaths, multi-fatality incidents, severe injuries); cumulative operational stress from repeated high-risk situations and long-term wear and tear; stigma and reluctance to seek help, which often prevents early intervention and functional impairments in personal, social, and occupational roles caused by stress injuries, are some of the problems this guide tends to address.

5. Description of the Practice

The implementation of Stress First Aid (SFA) follows a structured flexible process (7 steps) designed to be integrated into the daily operations of fire and EMS organisations. It is not a one-time intervention but an ongoing system of care that peers, supervisors, and leaders apply in natural work settings whenever stress reactions are observed.

The process begins with **Check**, which involves continuous observation and assessment of personnel for signs of distress or functional impairment. This step requires peers and supervisors to pay attention to behavioral changes, listen for verbal cues, and, when necessary, engage in one-on-one conversations to clarify concerns. The OSCAR communication technique (Observe, State, Clarify, Ask, Respond) is often used to guide these interactions. The goal is to determine whether the individual is coping adequately, needs additional SFA actions, or should be referred for higher-level care.

Once a need is identified, the next step is **Coordinate**, which focuses on mobilizing resources and informing those who need to know. This may involve collaborating with the affected individual to identify trusted peers or family members, informing the chain of command, and, when necessary, referring the person to a Behavioral Health Assistance Program (BHAP) or other professional services. Coordination ensures that the individual receives timely and appropriate support without overwhelming them.

The third step, **Cover**, addresses immediate safety concerns. This includes ensuring the physical safety of the individual and others, reducing perceived threats, and creating an environment of psychological security. Actions may range from removing someone from a hazardous situation to providing reassurance and reducing chaos at the scene. Cover is critical when stress reactions compromise situational awareness or decision-making.

Following safety, the **Calm** step aims to reduce physiological and emotional arousal. Techniques include grounding exercises, controlled breathing, and verbal reassurance. The objective is to restore mental clarity and emotional stability so the individual can regain control and function effectively. Calm may also involve providing time for rest and recovery.

Next, **Connect** focuses on restoring social support and reducing isolation. Stress often leads to withdrawal, so this step encourages reconnection with trusted peers, family,

and mentors. It may involve informal check-ins, structured peer support, or family meetings. Leaders play a key role in fostering a culture of openness and mutual support.

The sixth step, **Competence**, addresses the restoration or development of skills that may have been diminished by stress. This can include retraining, mentoring, and gradual re-exposure to duties. It also involves teaching coping strategies such as problem-solving, sleep hygiene, and stress management techniques. The goal is to rebuild confidence in one's ability to perform effectively in both professional and personal roles.

Finally, **Confidence** is about restoring self-esteem, trust, and hope. This step helps individuals make sense of their experiences, overcome guilt or shame, and set realistic goals for the future. Leaders and peers support this process through empathic communication, positive reinforcement, and rituals or ceremonies that honor resilience and recovery.

Throughout all these steps, the primary actors are peers, company officers, and trained members of peer support teams, with escalation to behavioral health professionals when necessary. The tools used include structured communication techniques, After Action Reviews, mentoring programs, and wellness resources. Together, these elements create a comprehensive system that addresses stress at multiple levels, from prevention to recovery.

6. Outcomes and Impact

Recent evaluations of Stress First Aid provide valuable insights into its effectiveness and implementation outcomes across different high-stress professions, including firefighters and healthcare workers.

A cluster randomized controlled trial conducted in U.S. fire departments assessed the impact of SFA on mental and behavioral health over a 10–12 month period. The study involved 400 firefighters, with a subset of 79 providing detailed feedback on training modules. Results showed high satisfaction rates with all components of the program: peer team training (97.6%), online SFA (94.9%), curbside manner (88.4%), and After Action Review (89.4%). Importantly, SFA significantly improved firefighters' perception of their department's ability to address behavioral health issues (mean score 3.93 vs. 3.50 in the control group, $p = 0.042$). While the study did not report large-scale reductions in clinical symptoms, it demonstrated that SFA enhanced organizational readiness and peer support culture, which are critical mediators for long-term resilience.

In healthcare settings, SFA was adapted during the COVID-19 pandemic to address chronic stress among frontline workers. A mixed-methods evaluation in the Veterans Health Administration found that the program was rated highly for acceptability, appropriateness, and feasibility. Participants reported increased awareness of stress, improved ability to support peers, and a sense of being valued and connected. Qualitative feedback highlighted that SFA normalized stress reactions and provided a shared language for discussing mental health. However, the intervention had limited impact on systemic sources of burnout, suggesting that while SFA is effective for

peer-level support, it should be combined with organizational changes for maximum benefit.

Another large-scale implementation study during the pandemic used a train-the-trainer model across hospitals and health centers. Findings indicated that leadership buy-in, protected time, and team-based approaches facilitated successful adoption, while barriers included time constraints, scheduling difficulties, and pandemic-related disruptions. Despite these challenges, SFA was generally well-received and considered sustainable by many sites, though some expressed concerns about maintaining the program without structural support.

Overall, the evidence suggests that SFA is effective in improving organizational readiness, peer support, and stress awareness, and it is highly acceptable to participants. While its direct impact on reducing clinical symptoms like PTSD or depression remains modest, SFA plays a crucial role in early intervention, stigma reduction, and fostering a supportive culture.

7. Lessons Learned and Success Factors

One of the success factors is its peer-to-peer approach made it highly acceptable within the fire and EMS culture, which traditionally values camaraderie and mutual support. By training firefighters and EMS personnel to monitor and assist each other, SFA reduced stigma around mental health and normalized conversations about stress. Another major contributor was its flexibility and integration into daily operations—SFA is not a one-time intervention but an ongoing process that can be applied in natural work settings, making it practical and sustainable. Leadership support also played a critical role; departments that embraced SFA as part of their organizational culture saw higher engagement and better outcomes. Additionally, the program's foundation in evidence-based principles, such as promoting safety, calming, connectedness, self-efficacy, and hope, gave it credibility and effectiveness.

However, it was noted a persistent stigma within the fire service, where seeking help for stress was often perceived as a weakness. This was addressed by framing SFA as a strength-based, operational tool rather than a clinical intervention, and by using respected peers as trainers and role models. Another challenge was time constraints and competing priorities, especially during emergencies or high-demand periods. Departments overcame this by embedding SFA into routine practices and providing short, scenario-based training sessions rather than lengthy classroom programs. Resource limitations also posed difficulties, particularly in smaller departments without dedicated behavioral health staff. To mitigate this, SFA emphasised low-cost, peer-driven strategies and created clear pathways for escalation to professional care when needed. Finally, maintaining momentum after initial training was a concern; successful programs addressed this by incorporating SFA into standard operating procedures, conducting regular refreshers, and using After Action Reviews to reinforce its principles.

8. Transferability and Adaptability

This practice can be adapted to other contexts or regions. can be adapted to other contexts and regions because its core principles—peer support, early intervention, and promoting resilience—are universal in high-stress professions. The model is flexible

and designed to operate within natural work environments, making it suitable for healthcare workers, law enforcement, military personnel, humanitarian responders, and even corporate teams facing chronic stress or crisis situations.

To apply SFA in a new context, the first step is cultural adaptation. For example, in regions where mental health stigma is strong, framing SFA as a performance and safety tool rather than a psychological intervention can increase acceptance. Similarly, language and terminology should be localized to reflect cultural norms and values. The peer-to-peer structure remains central, but the identity of "peers" will vary—nurses for nurses, teachers for teachers, etc.

In humanitarian or disaster relief contexts, SFA can be embedded into team briefings and debriefings. In corporate environments, it can be linked to employee wellness programs and leadership development initiatives.

Finally, systemic support is essential for sustainability. While SFA addresses individual and team-level stress, it does not eliminate structural stressors such as excessive workload or lack of organizational support. Therefore, successful adaptation should pair SFA with organizational policies that promote psychological safety, provide access to higher levels of care, and ensure ongoing training and evaluation.

9. Ethical Considerations

The manual does not explicitly outline formal ethical protocols, but several ethical considerations are implied in its design and application. The manual emphasises that SFA is primarily delivered by peers and supervisors within the natural work environment, which means sensitive information about stress reactions or personal struggles may be disclosed. To maintain trust, SFA providers are expected to share information only on a need-to-know basis, particularly when coordinating care or escalating to higher levels of support. For example, the "Coordinate" step advises involving others only when necessary and, whenever possible, doing so in collaboration with the affected individual. This approach minimizes unnecessary disclosure and respects the individual's privacy.

Second, informed consent is addressed indirectly through the voluntary nature of participation. SFA is not a mandatory clinical intervention but a supportive process embedded in daily operations. Individuals can choose whether to engage in conversations, accept referrals, or participate in follow-up actions. The manual also stresses that SFA providers should respect personal boundaries and avoid overstepping their role, which aligns with the ethical principle of autonomy.

Finally, duty of care and safety override confidentiality in cases where there is imminent risk, such as suicidal ideation or threats to others. The manual explicitly states that any suicide threat must be taken seriously and referred immediately to emergency or behavioral health professionals. This ensures that ethical obligations to protect life and safety are prioritized.

10. References

Jahnke, S. A., Watson, P., Leto, F., Jitnarin, N., Kaipust, C. M., Hollerbach, B. S., Haddock, C. K., Poston, W. S. C., & Gist, R. (2023). Evaluation of the implementation of

the NFFF Stress First Aid intervention in career fire departments: A cluster randomized controlled trial. International Journal of Environmental Research and Public Health, 20(22), 7067. https://doi.org/10.3390/ijerph20227067

National Fallen Firefighters Foundation. (2013). Stress First Aid for firefighters and emergency medical services personnel: Student manual. National Fallen Firefighters Foundation.

Resource 3

1. Title of the Best Practice

Supporting Psychological Health in Alberta's First Responders - Building Sustainable Mental Health Programs for Stronger Rural Communities (Canada)

2. Related Training Module

Module 2 - Stress Management Techniques

3. Context and Background

The Rural First Responder Mental Health Program was launched in Alberta, Canada, in response to the growing mental health challenges faced by first responders and their families, particularly in rural, remote, and Indigenous communities. The initiative began with funding through the Supporting Psychological Health in First Responders (SPHIFR) Stream 1 grants in 2021–22 and 2022–23, and was extended with a 2024–25 grant of $185,435.29 from the Alberta Municipal Health and Safety Association (AMHSA). The program was designed to address the psychological toll of traumatic incidents that first responders regularly face, which has led to a significant increase in post-traumatic stress injuries (PTSI) and related compensation claims in Alberta.

The program was implemented province-wide, with a strong emphasis on reaching underserved areas such as First Nations Reserves, Métis Settlements, and small municipalities. It targeted first responders across various disciplines—fire services, paramedics, healthcare workers, law enforcement, and Indigenous emergency personnel—along with their families. The inclusion of families was a key development introduced during the 2022–23 grant cycle, following survey data that revealed high levels of concern among family members about the impact of the first responder role on household relationships and well-being.

The core of the initiative is the delivery of **The Working Mind First Responders (TWMFR) training**, developed by the Mental Health Commission of Canada. This evidence-based program aims to reduce stigma, build resilience, and promote mental wellness. However, earlier evaluations showed that the benefits of the training diminished over time, prompting the need for a more sustainable model. The 2024–25 grant supports the training of approximately 48 new TWMFR Facilitators who will be embedded within their own communities and organisations. These facilitators will undergo five consecutive full-day training sessions and, upon completion, will be certified to deliver both standard and family-focused sessions.

To support long-term engagement, facilitators will receive digital credentials through AMHSA's partner Credly, which can be shared professionally. Participants also gain access to Espri by TELUS Health, a mobile app offering booster training and self-management tools. The program is culturally sensitive and adaptable, allowing for discipline-specific sessions while maintaining flexibility based on community needs.

4. Objectives of the Practice

The objectives of 'The Working Mind First Responder Facilitator Certification Training' are centered on building sustainable mental health capacity within first responder organizations and communities. The program aims to certify leaders as facilitators so they can deliver the evidence-based The Working Mind First Responders (TWMFR) program and its Family Package sessions locally, ensuring ongoing access to mental health education and support.

Specifically, the training seeks to familiarize participants with the Mental Health Commission of Canada's (MHCC) mandate and programs, and to explain how these courses align with national mental health strategies. It also aims to teach adult learning principles and facilitation strategies relevant to mental health education, preparing facilitators to deliver TWMFR effectively in both virtual and in-person environments. Another key objective is to provide a practical forum for participants to practice facilitation skills, receive feedback, and demonstrate competency through assessments. Finally, the program ensures that facilitators understand and adhere to the administrative and logistical requirements for maintaining certification and delivering the program consistently.

The overarching goal is to reduce stigma, improve resilience, and promote mental health awareness among first responders and their families, while empowering local leaders to create sustainable, culturally relevant mental health support systems within their communities.

5. Description of the Practice

This Facilitator Certification Training course enables participants to deliver the evidence-based The Working First Responders program directly to their organisations and communities, whenever and wherever it's needed, enhancing the sustainability of positive changes in first responder mental health.

Throughout the course, first responders will learn the five skills of being a The Working Mind First Responders facilitator through a blend of group discussions, exercises, workbook activities, and hands-on practice sessions. They also complete pre-training and post-training components, in addition to a final practical and written assessment.

A Lead Facilitator provide coaching and feedback, ensuring participants gain the necessary skills and tactics to create engaging learning environments, deliver helpful feedback, and effectively teach The Working Mind First Responders Primary, Leadership, and Families programs.

Facilitator Certification Training 5 day Course Outline:

Day 1: TWMFR Course Demonstration

Day 2: Session 2 – Creating a Welcoming and Safe Learning Environment – Session 2 Quiz

Day 3: Session 3 – Engage Participants and Foster Learning – Session 3 Quiz

Day 4: Session 4 – Assess Learning and Give/Receive Feedback – Session 4 Quiz

Day 5: Speaker Assessment. Each participant will facilitate a 20-minute section of the course and be assessed by the Lead Facilitator.

After the course: Session 5: Adhere to the Administrative and Logistical requirements as Certified Facilitator with MHCC/OM

6. Outcomes and Impact

The Working Mind First Responder Facilitator Certification Training has been evaluated primarily through surveys and program reviews. Overall, the program is highly regarded for its evidence-based approach to reducing stigma, improving mental health literacy, and building resilience among first responders. Participants consistently report that the training increases their confidence in recognizing signs of mental health decline, engaging in supportive conversations, and applying coping strategies. The facilitator training component is particularly valued for its practical, hands-on approach, which includes group discussions, exercises, and assessments to ensure facilitators can effectively deliver the program in their communities.

However, evaluation data also reveal challenges in sustaining long-term impact. A follow-up survey conducted three months after program completion with fire, EMS, police, and healthcare personnel in urban, remote, and Indigenous communities found that initial positive changes in stigma reduction and resilience were not fully maintained. Respondents reported a return of negative attitudes toward mental health, decreased resilience, and reduced engagement in self-care activities. These findings underscore the need for ongoing resources, refresher training, and organizational support to reinforce the program's benefits over time.

Meta-analyses of The Working Mind program (including its first responder adaptation) show that it is effective in improving mental health knowledge and reducing stigma in the short term, with moderate effect sizes across diverse workplace settings. However, like many psychoeducational interventions, its long-term effectiveness depends on continuous reinforcement and integration into workplace culture.

In summary, the TWMFR Facilitator Certification Training is successful in equipping leaders to deliver mental health education and fostering immediate improvements in awareness and attitudes, but sustaining these gains requires systemic support, booster sessions, and cultural change within organizations.

7. Lessons Learned and Success Factors

One of the most significant contributors to the program's success was its community-based and culturally sensitive approach. By training facilitators from within the communities they serve—whether rural, remote, or Indigenous—the program ensured that mental health support was both accessible and relevant. This local ownership fostered trust and engagement, which are essential in addressing stigma and encouraging participation. The inclusion of family-focused sessions also strengthened the program's impact, recognizing that the mental health of first responders is deeply interconnected with their home environments.

Another success factor was the use of evidence-based training through the program, developed by the Mental Health Commission of Canada. This curriculum provided a structured, research-backed framework for building resilience and reducing stigma.

The addition of digital tools, such as the Espri by TELUS Health app and digital credentials via Credly, helped extend the reach and sustainability of the training, allowing participants to continue learning and sharing their achievements beyond the classroom.

However, the program faced several challenges. One major issue was the short-lived impact of initial training sessions. Follow-up surveys revealed that participants often experienced a return of stigma and a decline in resilience and self-care within three months of completing the training. To overcome this, the program shifted toward a train-the-trainer model, empowering local facilitators to deliver ongoing sessions and maintain momentum within their organizations. This approach not only addressed the sustainability gap but also allowed for more frequent and tailored interventions.

Another challenge was ensuring discipline-specific relevance across diverse first responder roles. While the program aimed to offer sessions tailored to fire services, healthcare, law enforcement, paramedics, and Indigenous communities, logistical constraints sometimes required flexibility. The program responded by maintaining adaptable content and scheduling, allowing facilitators to adjust based on participant needs and uptake.

8. Transferability and Adaptability

The Rural First Responder Mental Health Program offers a flexible and scalable model that can be adapted to other regions and contexts, especially those facing similar challenges with access to mental health support for emergency personnel and their families.

One of the most transferable aspects of the program is its train-the-trainer model, which builds local capacity by certifying facilitators within their own communities. This approach ensures sustainability and cultural relevance, making it ideal for rural, remote, or underserved areas where external resources may be limited. By empowering local leaders to deliver mental health training, other regions can foster trust and engagement while reducing reliance on centralized services.

The program's use of evidence-based curriculum, such as The Working Mind First Responders also makes it adaptable. This training can be customised to suit different first responder disciplines—fire services, paramedics, law enforcement, healthcare workers—and can be modified to reflect the cultural and operational realities of each region. For example, in areas with large Indigenous populations, the curriculum can be tailored to include culturally sensitive content and delivery methods, as was done in Alberta.

Another key element that can be replicated is the integration of digital tools. The use of mobile apps like Espri by TELUS Health for booster training and self-care, along with digital credentialing through platforms like Credly, enhances accessibility and engagement. These tools allow participants to continue learning and sharing their achievements, which is especially valuable in geographically dispersed communities.

9. Ethical Considerations

Confidentiality was a central concern throughout the program. Training sessions, especially those involving personal experiences or mental health disclosures, were

conducted in a manner that respected participants' privacy. Facilitators were trained to create safe spaces where individuals could share without fear of judgment or exposure. Any data collected through surveys or feedback mechanisms was anonymized and used solely for program evaluation and improvement. The use of digital tools like the Espri app also adhered to privacy standards, ensuring that personal information and usage data were protected under applicable laws and platform policies.

Informed consent was another critical component. Participants were required to complete application forms and submit Letters of Support, which outlined the nature of the training, its goals, and what would be expected of them. Before beginning the facilitator training, individuals signed a Facilitator Agreement that clarified their roles, responsibilities, and the ethical standards they were expected to uphold. This process ensured that all participants understood the scope of their involvement and had the opportunity to ask questions or opt out without penalty.

Additionally, the program was designed with cultural sensitivity in mind, particularly for Indigenous communities. Care was taken to respect traditional knowledge systems, community protocols, and the unique experiences of Indigenous first responders and their families. This ethical approach helped build trust and foster meaningful engagement.

10. References

Alberta Municipal Health and Safety Association. (2023, November). AMHSA First Responder 2.0 Fact Sheet [PDF]. Rural First Responder. https://ruralfirstresponder.ca/wp-content/uploads/2023/11/AMHSA-First-Responder-2.0-Fact-Sheet_V6.pdf 1

Alberta Municipal Health and Safety Association. (2023, September). AMHSA First Responders Family Package [PDF]. Rural First Responder. https://ruralfirstresponder.ca/wp-content/uploads/2023/09/AMHSA-First-Responders-Family_v3-1.pdf 2

Dobson, K. S., Szeto, A., & Knaak, S. (2019). The Working Mind: A meta-analysis of a workplace mental health and stigma reduction program. The Canadian Journal of Psychiatry, 64(1_suppl), 39S–47S. https://doi.org/10.1177/0706743719842559

Government of Alberta. (2025, March). Supporting Psychological Health in First Responders – Stream 1: Services Grant Application Instructions [PDF]. OHS Resource Portal. https://ohs-pubstore.labour.alberta.ca/grt001 4

Knaak, S., Szeto, A., & Dobson, K. (2019). Evaluation of workplace mental health training programs: The Working Mind and The Working Mind First Responders. Opening Minds Initiative, Mental Health Commission of Canada.

Rural First Responder. (n.d.). The Working Mind First Responder Facilitator Certification Training. https://ruralfirstresponder.ca/

Resource 4

1. Title of the Best Practice

911 At Ease International (911AEI) – USA

2. Related Training Module

Module 2

3. Context and Background

911 At Ease International (911AEI) was established to address the growing mental health crisis among first responders, **a group that includes firefighters, police officers, paramedics, and their immediate families**. The organisation emerged in response to the unique psychological challenges these professionals face due to repeated exposure to traumatic events, such as natural disasters, violent crimes, and large-scale emergencies. These experiences often lead to stress, post-traumatic symptoms, and emotional strain that can severely impact both professional performance and personal well-being.

The program originated in the United States and has since expanded across multiple states, offering free, confidential counseling and mental health support. Its implementation was driven by the recognition that first responders often avoid seeking help due to stigma, cost, and bureaucratic barriers. By removing these obstacles, 911AEI ensures that those who dedicate their lives to protecting communities can access timely and judgment-free care.

The target group for this initiative is first responders and their families, who are disproportionately affected by trauma-related mental health issues. The geographic setting spans various regions in the U.S., particularly areas prone to disasters such as wildfires, floods, and other emergencies. The program's relevance became even more pronounced following high-profile crises and the increasing awareness of suicide rates among first responders. Through initiatives like Project Harmony, which uses music as a tool for healing, 911AEI continues to expand its reach and impact, fostering resilience and recovery within this critical workforce.

4. Objectives of the Practice

The main objectives of 911 At Ease International (911AEI) are centered on improving the mental health and overall well-being of first responders and their families. The organisation aims to provide free, confidential, and stigma-free counseling services to those who routinely face traumatic and high-stress situations in the line of duty. It seeks to create a safe space where first responders can seek help without fear of professional repercussions or social judgment.

Additionally, the organization **aims to reduce barriers to mental health care by ensuring accessibility and confidentiality**, which are critical in professions where stigma often prevents individuals from seeking support. It also works to promote resilience and long-term wellness through early intervention and ongoing support,

recognising that untreated stress and trauma can lead to burnout, substance abuse, and other serious consequences.

5. Description of the Practice

The process begins when a first responder or their family member reaches out for help. This can be done through the 911AEI website, a dedicated phone line, or referrals from partner agencies. The organisation emphasises ease of access, ensuring there are no financial costs, insurance requirements, or bureaucratic delays.

Once contact is made, a confidential intake process is conducted. This step involves gathering basic information about the individual's situation, mental health needs, and urgency level. The confidentiality aspect is critical to overcoming stigma and encouraging participation.

911AEI maintains a network of licensed, trauma-informed clinicians who specialise in working with first responders. Based on the intake assessment, the individual is matched with an appropriate counselor. These professionals understand the unique culture and stressors of emergency services.

Counseling sessions are provided free of charge and can be conducted in person or virtually, depending on the client's preference and location. The sessions focus on trauma recovery, stress management, and coping strategies. The organization uses evidence-based therapeutic approaches tailored to first responders' needs.

After initial sessions, 911AEI offers continued support to ensure long-term well-being. This may include additional counseling, peer support connections, and referrals to specialized care if needed. The organization also runs community-based programs like Project Harmony, which uses music therapy to help first responders process trauma creatively.

The program is sustained through community donations, partnerships, and fundraising events. Local agencies and businesses often collaborate to expand services and reach more first responders.

6. Outcomes and Impact

The results of 911 At Ease International's (911AEI) practice demonstrate a significant positive impact on the mental health and well-being of first responders and their families. According to the organisation, thousands of clinical hours have been delivered across multiple states, providing confidential, trauma-informed care to those in need. While exact numbers vary by year, the program reports steady growth in both the number of clients served and the geographic reach of its services, reflecting strong demand and community support.

Feedback from participants highlights the program's effectiveness in reducing barriers to mental health care. Testimonials from firefighters, police officers, and family members emphasise that the confidentiality, ease of access, and cost-free nature of the service were critical in encouraging them to seek help. Many describe the counseling as "life-changing," helping them cope with traumatic experiences, prevent burnout, and, in some cases, recover after severe crises such as suicide loss or exposure to violent incidents.

Qualitative outcomes also indicate that the program reduces stigma around mental health within first responder communities. Leaders such as fire captains and police chiefs have publicly endorsed the initiative, noting its role in keeping personnel strong and resilient. Additionally, innovative programs like Project Harmony, which uses music as a therapeutic tool, have expanded the organization's impact by offering creative avenues for healing.

Although formal quantitative evaluations are limited, the combination of growing participation, geographic expansion, and overwhelmingly positive testimonials suggests that 911AEI is effectively addressing a critical gap in mental health support for first responders.

7. Lessons Learned and Success Factors

One of the most significant contributors to success was the program's commitment to confidential, stigma-free, and cost-free services. First responders often avoid seeking help due to fear of judgment or career repercussions. By guaranteeing privacy and removing financial barriers, 911AEI created a safe environment that encouraged participation.

The program's expansion was made possible through strong community backing and donations. Local agencies, businesses, and individuals provided financial and logistical support, allowing the organization to scale its services across multiple states.

911AEI employs licensed clinicians trained in trauma and first responder culture, which builds trust and ensures that counseling is relevant and effective. This cultural competence was key to overcoming skepticism within the first responder community. Programs like Project Harmony, which uses music as a therapeutic tool, introduced creative ways to process trauma, making the initiative more engaging and impactful.

Regarding the challenges, initially, many first responders were reluctant to seek help due to stigma. 911AEI addressed this by emphasizing confidentiality and promoting success stories from peers, which normalized mental health care within the community. As demand grew, sustaining free services became a challenge. The organization overcame this by building strong donor networks and community partnerships, ensuring financial stability for program expansion. Scaling services to multiple states required recruiting qualified clinicians and maintaining consistent quality. 911AEI tackled this by creating a network of vetted, trauma-informed professionals and leveraging virtual counseling options to reach remote areas.

8. Transferability and Adaptability

The 911 At Ease International (911AEI) model can be successfully adapted to other contexts or regions making it effective in reducing stigma and encouraging individuals in high-stress professions to seek help.

To apply this model elsewhere, the first step is to ensure that mental health services remain free of charge and confidential, as financial and privacy concerns are major barriers to care. This principle is universally relevant, whether the target group is first responders, healthcare workers, or humanitarian aid personnel. Another critical factor is cultural adaptation. Counselors must understand the unique pressures and values

of the group they serve. For example, in regions where community and family ties are strong, involving family counseling might enhance effectiveness, while in military contexts, integrating peer support could be essential.

The model is particularly suitable for disaster-prone regions or areas experiencing prolonged crises, such as conflict zones or pandemic-affected communities. In these settings, the psychological toll on emergency workers and volunteers is immense, and a program modeled after 911AEI could provide timely, life-saving support. To overcome geographic and infrastructure challenges, telehealth platforms can be leveraged, ensuring that even remote or underserved areas have access to care. Where internet access is limited, mobile counseling units or partnerships with local clinics could serve as alternatives.

9. Ethical Considerations

An important ethical consideration in the implementation of 911 At Ease International (911AEI) is the protection of confidentiality. The program was designed to ensure that first responders and their families could seek mental health support without fear of stigma, professional repercussions, or breaches of privacy. All counseling sessions are conducted under strict confidentiality agreements, and no information is shared with employers, agencies, or third parties without explicit consent. This commitment to privacy is one of the key reasons why the program successfully overcame cultural barriers and encouraged participation.

10. References

911 At Ease International. (n.d.). About us. 911 At Ease International. Retrieved from https://911aei.org/

911 At Ease International. (n.d.). Project Harmony. 911 At Ease International. Retrieved from https://911aei.org/project-harmony/

Resource 5

1. Title of the Best Practice

Acute Stress Adaptive Protocol (USA)

2. Related Training Module

Module 2

3. Context and Background

The Acute Stress Adaptive Protocol (ASAP) was derived from Elan Shapiro's pioneering contributions to evolve Eye Movement Desensitization and Reprocessing (EMDR) techniques to meet the unique needs of first responders through structured, peer-delivered applications. **EMDR** is a type of psychotherapy that helps individuals process distressing memories and reduce symptoms of post-traumatic stress disorder (PTSD) and other trauma-related issues.

Acute Stress Adaptive Protocol addresses the need for a culturally competent, effective, and accessible method for trauma recovery among first responders. The protocol was designed to address the unique psychological toll of repeated exposure to critical incidents, such as violence, death, and high-stress emergencies. The goal is to offer a peer-deliverable, evidence-based intervention that could reduce symptoms of post-traumatic stress injury and promote resilience.

ASAP is primarily implemented in the Pacific Northwest, especially in Oregon and Washington, where First Responder Psychology is based. Trainings and sessions have been held in locations like Tacoma, WA, and Portland, OR, often in collaboration with local police departments, fire services, and church programs. ASAP is designed for: Police officers, Firefighters, Paramedics, Dispatchers, Priests, Peer support team members. It is safe for use by trained peer supporters, clinicians, and chaplains, even if they are not licensed mental health professionals, thanks to its structured and silent EMDR-based format.

4. Objectives of the Practice

This protocol is a trauma-informed intervention developed specifically for first responders to help them process stressful and traumatic events. It was created by a former law enforcement officer turned EMDR therapist to address the unique psychological toll of repeated exposure to critical incidents such as violence, death, and high-stress emergencies.

ASAP's main objectives are to:

- Significantly reduce symptoms of post-traumatic stress injury, with studies showing a 50–66% reduction.
- Provide immediate, accessible support through peer-delivered sessions that do not require clinical degree.
- Promote resilience and preventative care by helping responders process stress before it escalates.

- Ensure confidentiality and safety, allowing participants to process trauma silently without sharing personal details.
- Empower peer support networks with tools to recognize trauma reactions and support colleagues effectively.

ASAP is designed to be used immediately after an incident or years later, in both individual and group settings, making it a flexible and powerful tool for trauma recovery and resilience building.

5. Description of the Practice

ASAP begins with the training of facilitators, which includes peer support team members, chaplains, and clinicians. These individuals receive structured instruction from experienced trauma professionals, learning how to safely and effectively deliver the protocol. The training covers the neurobiology of trauma, stress regulation techniques, and the use of EMDR-based tools.

Once trained, facilitators organise a session, which can be conducted individually or in a group. The setting is quiet and private, designed to ensure confidentiality and emotional safety. No personal details are shared during the session, and no records are kept.

The session starts with a brief introduction phase, lasting about five to ten minutes. During this time, the facilitator explains the process and sets expectations. Participants are reassured that they will not need to speak or disclose any personal information.

Next, the group engages in stress management exercises. These include breathing techniques, grounding strategies, and imagery designed to regulate the nervous system. These exercises help participants prepare mentally and physically for the core processing work.

The heart of the protocol involves adaptive processing rounds. Participants silently undergo three rounds of bilateral stimulation, a technique derived from EMDR therapy. This may involve visual tracking, tapping, or other rhythmic movements that stimulate both sides of the brain. The goal is to help the brain reprocess traumatic memories in a safe and non-verbal way.

After the processing rounds, the session concludes with a closing activity. This may include calming exercises, visualisation, or reflective practices to help participants return to a regulated state. The facilitator ensures that everyone feels grounded and supported before ending the session.

Finally, if needed, participants are offered optional follow-up support. This could include referrals to mental health professionals or additional wellness resources. However, many find that a single ASAP session provides significant relief.

6. Outcomes and Impact

The implementation of the ASAP has yielded notable results in improving the mental health and resilience of first responders. Evaluations of the protocol show that participants experience a significant reduction in post-traumatic stress symptoms, with studies reporting decreases ranging from 50% to 66%. These outcomes have

been observed across both individual and group sessions, indicating that the protocol is effective in various formats.

Feedback from participants consistently highlights the practicality, safety, and cultural relevance of ASAP. First responders appreciate that the protocol allows them to process trauma without speaking or disclosing personal details, which helps preserve confidentiality and reduces stigma. Many have described ASAP as the first intervention that truly feels tailored to their experiences in the field.

Training evaluations also reflect strong positive responses. Participants frequently praise the instructors for their credibility and relatability, especially when the trainers have backgrounds in law enforcement or emergency services. Comments from trainees include appreciation for the inclusion of dispatchers, the evidence-based nature of the content, and the engaging delivery style.

ASAP has been successfully adopted by multiple agencies in the Pacific Northwest, including police departments, fire services, and religious programs. It is endorsed by union representatives and considered safe for use even during internal investigations, thanks to its non-disclosure format and lack of record-keeping.

Overall, ASAP is recognised not only as a therapeutic tool but also as a preventative measure, helping first responders build resilience before symptoms escalate. Its combination of accessibility, effectiveness, and cultural competence makes it a valuable addition to wellness programs in high-stress professions.

7. Lessons Learned and Success Factors

ASAP's success is rooted in its cultural relevance, accessibility, and evidence-based design. Another major factor is the non-verbal format of ASAP. Participants are not required to speak or share personal details during sessions, which preserves confidentiality and reduces stigma. This feature has made ASAP especially appealing in environments where trust and privacy are critical, such as during internal investigations or union-sensitive situations.

The protocol is also highly accessible. It can be delivered by trained peer supporters, chaplains, and clinicians—even those without formal mental health degree. This flexibility allows agencies to integrate ASAP into their wellness programs without relying solely on external therapists. The training process is robust, with ongoing support from EMDR clinicians to ensure safe and competent delivery.

ASAP's effectiveness is backed by data showing a 50–66% reduction in post-traumatic stress symptoms, and it is used both preventatively and reactively. Agencies have found it helpful for processing both acute incidents and cumulative stress.

However, there was an initial skepticism from first responders, many of whom were wary of mental health interventions due to past experiences with providers who lacked cultural competence. This was overcome by ensuring that ASAP trainers and facilitators had firsthand experience in emergency services, which built credibility and trust. Feedback from participants frequently highlights the value of learning from someone who "speaks our language" and "gets it".

Another challenge was ensuring consistent quality across facilitators. To address this, ASAP includes structured training, refresher courses, and access to clinical

supervision. These measures help maintain fidelity to the protocol and ensure that peer supporters feel confident and supported in their roles

8. Transferability and Adaptability

The Acute Stress Adaptive Protocol (ASAP) has proven to be adaptable and effective across various settings, and its success in first responder communities offers a strong foundation for broader application. Its potential for use in other contexts and regions lies in its simplicity, flexibility, and cultural sensitivity.

ASAP can be applied to other high-stress professions such as healthcare, military, humanitarian aid, education, and social services. These fields often involve repeated exposure to trauma, emotional exhaustion, and high-pressure environments—conditions similar to those faced by first responders. Because ASAP does not require participants to speak or disclose personal details, it can be used in settings where privacy and stigma are major concerns. This silent, non-clinical format makes it especially suitable for professions where individuals may be reluctant to seek traditional mental health support.

To adapt ASAP to different regions, the training and materials can be localized. This includes translating content, incorporating culturally relevant examples, and involving trainers who understand the specific challenges of the target population. Partnering with local agencies—such as hospitals, schools, or military units—can help integrate ASAP into existing wellness programs. Training peer supporters within these communities ensures sustainability and builds trust.

Challenges in applying ASAP to new contexts may include skepticism about mental health interventions, lack of trained facilitators, and institutional resistance. These can be addressed by emphasising ASAP's evidence-based outcomes, offering accessible training formats, and highlighting its success in similar environments. The use of trainers with lived experience in the target profession also helps overcome resistance and fosters credibility.

9. Ethical Considerations

One of the most important ethical features of ASAP is its commitment to confidentiality. No records are kept of who attends a session or what occurs during it. Because participants do not speak or share personal details during the session, their reasons for attending remain entirely private. This structure allows ASAP to be used even in situations involving gag orders or internal investigations, and it has been approved by union representatives for such cases.

Facilitators are the only ones who speak during the session, and participants engage silently in the protocol. This approach not only protects privacy but also reduces the risk of re-traumatisation or discomfort that might arise from verbal disclosure. It also helps overcome stigma and fear of judgment, which are common barriers to seeking mental health support in first responder communities.

In terms of informed consent, ASAP is delivered by trained peer supporters, and clinicians who receive extensive instruction in trauma-informed care. These facilitators are taught to explain the process clearly at the beginning of each session,

including what participants can expect and how the protocol works. This introduction phase ensures that individuals understand the nature of the intervention and can choose to participate voluntarily.

Additionally, facilitators are trained to recognise when a participant may need further support and are prepared to offer referrals to licensed clinicians if necessary. This ensures that participants have access to appropriate follow-up care and that the protocol remains within ethical boundaries regarding scope of practice.

10. References

List all sources used, formatted in APA 7th edition style.

Conn, S. M. (n.d.). Acute Stress Adaptive Protocol (ASAP). First Responder Psychology. Retrieved August 31, 2025, from https://firstresponderpsychology.com/asap

RESILIENT RESPONDERS

Psychological Resilience and Support for Personnel in Charge after Natural Disasters

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