Resilient Responders Best Practices Repository for Module 3

Prepared by ANIMAM

Resource 1

1. Title of the Best Practice

Online course on Psychological First Aid: Supporting Children and Young People (UK)

2. Related Training Module

Module 3 - Psychological First Aid

3. Context and Background

The course “Psychological First Aid: Supporting Children and Young People” was created in the United Kingdom by Public Health England, in collaboration with a range of experts and organisations. It was developed in response to the urgent need for mental health support during emergencies, particularly highlighted during the COVID-19 pandemic. The pandemic revealed how deeply children, young people, and families were affected by crisis situations, and how essential it was to equip those working with them—such as frontline workers, volunteers, and caregivers—with practical tools to offer emotional support.

This is a three-week online course (1 hour per week) designed to teach the principles and techniques of Psychological First Aid. The course is based on guidance from the World Health Organization, the United Nations, and other global partners, making it relevant and applicable across different countries and contexts.

The course is accessible to anyone, regardless of prior experience or qualifications. It is firstly developed to frontline or essential workers and volunteers who come into contact with children and young people aged 0-25 years during emergency and crisis situations. But those who may benefit from this course also include parents/ caregivers, front line workers or volunteers; or for young adults to support their peers or family.

It focuses on helping participants understand how emergencies impact mental health, especially in children and young people aged 0–25. It teaches how to recognise signs of distress, identify those at greater risk, and apply strategies to support them effectively. Participants, in an accessible way, learn the PFA framework—Prepare, Look, Listen, Link—, how to implement it with children and youth, and are also guided on how to care for their own mental wellbeing and support their colleagues. Educators involved in the course include professionals from public health, psychiatry, and behavioral science.

4. Objectives of the Practice

The main objectives of the course “Psychological First Aid: Supporting Children and Young People” are to equip individuals with the knowledge and skills needed to provide emotional and psychological support to children and young people during emergencies and crisis situations. It aims to help learners understand how distress manifests across different age groups, how to respond appropriately, and how to recognise when someone may need more specialised help.

The practice addresses several key problems. First, it tackles the lack of preparedness among caregivers, volunteers, and frontline workers in dealing with the psychological impact of emergencies, especially on younger populations. Most people in support roles are not trained to recognise signs of trauma or distress, which can lead to missed opportunities for early intervention. Second, it responds to the increased mental health challenges brought on by global crises like the COVID-19 pandemic, which disrupted lives and created widespread emotional strain. Third, it seeks to reduce the stigma around mental health by promoting compassionate, informed responses that prioritise safety, listening, and connection.

The course aims to:

- Explain what psychological first aid is;
- Identify children, young people and families for whom it is suited and how you can help them;
- Describe how children and young people of different ages react to traumatic experiences;
- Identify ways to look after yourself and your peers when working in the context of an emergency;
- Engage with further reading into psychosocial support during emergencies.

5. Description of the Practice

Throughout the course, learners engage with interactive content such as quizzes, case studies, and reflective exercises. The educators—experts in public health, psychiatry, and behavioral science—guide participants through each stage.

6. Outcomes and Impact

The course, hosted on FutureLearn and developed by Public Health England, has had over 92,000 enrollments and maintains a high rating of 4.5 out of 5 stars based on 1,349 reviews. This indicates strong engagement and positive reception among learners, many of whom are frontline workers, volunteers, and caregivers.

Participants report that the course significantly improved their understanding of how to support children and young people during emergencies. They appreciated the clarity of the PFA framework—Prepare, Look, Listen, Link—and found the practical strategies useful for real-life application. The inclusion of quizzes, scenario-based learning, and guidance on self-care were also highlighted as valuable components.

7. Lessons Learned and Success Factors

One of the most important contributors to the success of the practice was its timely launch during the COVID-19 pandemic, a period when children and young people were

experiencing heightened levels of stress, isolation, and uncertainty. The course responded directly to this urgent need by offering practical, accessible training to those in regular contact with young people, including teachers, health and social care workers, volunteers, and parents.

Another major factor was the collaborative development process. Public Health England worked with a wide range of experts and organisations—including NHS England, the Department for Education, the British Red Cross, and child mental health specialists—to ensure the course was evidence-based, developmentally appropriate, and aligned with international standards.

The course's flexible format also contributed to its success. It was delivered online via FutureLearn, free of charge, and designed to be completed in three short sessions. This made it accessible to a broad audience, regardless of prior qualifications or location. The inclusion of quizzes, scenario-based learning, and links to further resources helped reinforce learning and encouraged reflection.

8. Transferability and Adaptability

The practice of Psychological First Aid for Supporting Children and Young People is highly adaptable and can be applied in a wide range of contexts and regions, especially where children and youth are affected by emergencies, disasters, or conflict.

To apply this practice in other contexts, several factors should be considered like cultural adaptation as the emotional responses of children and young people to crises can vary across cultures. It's important to understand local norms around mental health and communication styles. Training materials should be translated and tailored to reflect these cultural nuances.

9. Ethical Considerations

While the course itself does not involve direct clinical practice, it prepares learners to engage with children and young people in ways that respect their autonomy. Participants are encouraged to seek permission before offering help, explain what they are doing and why, and ensure that individuals—especially older children and adolescents—understand and agree to the support being offered. This approach aligns with ethical standards of informed consent, adapted to the developmental level of the child.

Participants are reminded of their responsibilities under child protection laws, such as the UK's Children Act (2004). This includes recognising signs of harm or abuse and knowing how to respond appropriately. The course encourages learners to be aware of safeguarding protocols and to act in the best interest of the child when safety concerns arise.

10. References

Public Health England. (2021). Psychological First Aid: Supporting Children and Young People [Online course]. FutureLearn. https://www.futurelearn.com/courses/psychological-first-aid-for-children-and-young-people

Resource 2

1. Title of the Best Practice

Substance Abuse and Mental Health Services Administration (SAMHSA) - Responder Peer Support Programs - USA

2. Related Training Module

Module 3 - Psychological First Aid

3. Context and Background

The SAMHSA Responder Peer Support Programs emerged as part of a broader effort to address the mental health challenges faced by first responders, who experience significantly higher rates of stress, trauma, and substance use disorders compared to the general population. Although peer support in emergency services dates back to the 1970s with early initiatives like the Boston Police Department's critical incident stress programs, SAMHSA formalised its approach through the Disaster Technical Assistance Center to **provide structured, evidence-informed models for responder wellness**. These programs were implemented across the United States in law enforcement agencies, fire departments, EMS units, and disaster response organizations, particularly in the wake of large-scale crises such as natural disasters, mass casualty events, and public health emergencies like COVID-19.

The primary goal was to **reduce stigma around mental health, encourage early help-seeking, and provide culturally competent, immediate emotional support through trained peers who understand the unique pressures of emergency work**. By embedding peer support into organisational culture, SAMHSA aimed to strengthen resilience, improve recovery after critical incidents, and create a sustainable system of care for those who routinely face life-threatening and emotionally taxing situations.

4. Objectives of the Practice

The main objectives of the SAMHSA Responder Peer Support Programs are to **provide immediate, culturally competent emotional support to first responders following exposure to traumatic or high-stress events, reduce stigma associated with seeking mental health care, and encourage early intervention before stress reactions escalate into more severe conditions**. These programs aim to create a trusted, peer-driven support system where responders can openly discuss their experiences with colleagues who understand the unique demands of emergency work.

The problems these programs address include the high prevalence of post-traumatic stress disorder (PTSD), depression, anxiety, and substance use disorders among first responders, as well as the organizational culture that often discourages help-seeking due to fear of judgment or career repercussions. This initiative seeks to mitigate the psychological toll of repeated exposure to disasters, critical incidents, and life-threatening situations, ultimately improving resilience, job performance, and overall well-being within this workforce.

5. Description of the Practice

Phase 1: Program Preparation (Organizational Commitment)

Key Action: Agency leadership (e.g., fire chiefs, police command staff) collaborates with mental health professionals and SAMHSA advisors to define the program's goals, policies, and confidentiality standards.

Involved Actors: Agency Leadership, Mental Health Professionals, SAMHSA Advisors.

Outcome: Integration of peer support into the agency's official wellness strategy, prioritizing stigma reduction.

Phase 2: Peer Selection and Structured Training

Key Action: Peers are chosen from within the responder workforce based on trustworthiness, communication skills, and credibility.

Training: Selected peers undergo structured training using resources like the SAMHSA Peer Support Toolkit and the PFA Field Operations Guide. Training covers active listening, stress management, crisis intervention, and referral pathways.

Tools Used: Role-playing exercises, scenario-based learning, and the PFA Mobile App.

Involved Actors: Selected Responders (future Peers), Training Staff.

Phase 3: Program Rollout and Normalisation

Key Action: The program is introduced to the entire workforce through internal communications and wellness events.

Emphasis: Confidentiality and the non-punitive nature of seeking support are strongly emphasized to normalize its use.

Involved Actors: Agency Leadership, Peer Supporters, General Workforce.

Phase 4: Activation, Support, and Evaluation

Key Action: The peer support team is activated proactively or on request after a traumatic event (e.g., mass casualty incident, disaster deployment).

Support Provided: Peers offer emotional support, reflective listening, and practical coping strategies. They also monitor colleagues for signs of distress and connect them to professional mental health services when necessary.

Tools Used: Stress checklists and resource directories to guide referrals.

Evaluation: Agencies collect feedback (surveys, debriefings) to assess program effectiveness, with technical assistance often provided by SAMHSA for quality improvement.

Involved Actors: Peer Supporters, Colleagues (Recipients of Support), SAMHSA Technical Assistance.

6. Outcomes and Impact

Evaluations and feedback on SAMHSA's Responder Peer Support Programs indicate positive outcomes in reducing stigma, improving coping, and fostering team cohesion among first responders. While formal quantitative data is limited, multiple studies and program reviews highlight significant benefits. Peer support programs have been shown to lower barriers to seeking mental health care, which is critical in responder cultures where stigma and fear of career repercussions often prevent individuals from accessing help. According to SAMHSA, these programs help responders cope more effectively with the psychological toll of disasters and critical incidents, while also strengthening team relationships and promoting resilience.

Research summarized in SAMHSA's Disaster Technical Assistance Center reports that up to 30% of first responders develop behavioral health conditions such as PTSD and depression, compared to 20% in the general population, and suicide risk is significantly higher among firefighters and EMS personnel. Peer support programs address these risks by providing early, confidential, and culturally competent support, which has been associated with increased use of positive coping strategies and improved psychological safety within teams.

Qualitative feedback from agencies implementing peer support indicates that responders value the trust and shared experience peers bring, which makes them more likely to engage in conversations about mental health than with external clinicians. Studies also suggest that peer support contributes to post-traumatic growth, reduces feelings of isolation, and helps responders manage organizational stressors such as staffing shortages and bureaucratic pressures

7. Lessons Learned and Success Factors

What contributed to the success of SAMHSA's Responder Peer Support Programs was the inherent trust and shared experience among peers, which made responders more willing to seek help compared to traditional clinical settings. This cultural alignment helped reduce stigma and normalise conversations about mental health. Second, the use of structured training based on evidence-informed models like Psychological First Aid equipped peer supporters with practical skills in active listening, stress management, and referral pathways, ensuring that support was both empathetic and effective. Organisational leadership buy-in also played a critical role, as agencies that integrated peer support into their wellness policies and emphasized confidentiality saw higher engagement and sustainability of the program.

Relative to the challenges, one barrier was the persistent stigma within responder culture, where admitting psychological distress is often perceived as weakness or a career risk. To overcome this, agencies implemented awareness campaigns and leadership endorsements to reinforce that seeking help is a sign of strength. Another challenge was ensuring adequate training and preventing peer supporters from experiencing burnout themselves. This was addressed by providing ongoing supervision, refresher courses, and access to professional mental health resources for peer supporters. Finally, logistical issues such as staffing shortages and time constraints were mitigated by embedding peer support into existing operational structures, allowing responders to access help without disrupting their duties.

8. Transferability and Adaptability

The SAMHSA Responder Peer Support Program can adapted its peer-driven support, structured training, and stigma reduction to other contexts or regions. For example, in low-resource or rural areas, the program could be integrated into existing community emergency response teams or volunteer networks, using simplified training modules and mobile-based tools like one PFA Mobile App to overcome geographic barriers. In international or humanitarian settings, adaptation would require cultural sensitivity, such as incorporating local languages, norms around mental health, and community-based coping strategies.

For sectors beyond emergency services, such as healthcare, education, or humanitarian aid, the model can be applied by training trusted peers within those professions to provide emotional support and early intervention after high-stress events (e.g., pandemics, school crises, refugee response). Key success factors—such as leadership endorsement, confidentiality policies, and ongoing supervision—remain essential, but implementation might involve partnerships with NGOs, public health agencies, or faith-based organizations to ensure sustainability.

9. Ethical Considerations

Ethical considerations in implementing SAMHSA's Responder Peer Support Programs center on confidentiality, informed consent, and professional boundaries. Confidentiality is critical because first responders often fear that disclosing psychological distress could harm their careers. To address this, programs establish clear policies stating that conversations with peer supporters remain private unless there is an imminent risk of harm to self or others. Peer supporters are trained to explain these limits upfront, ensuring transparency and trust.

Informed consent is obtained by clearly communicating the voluntary nature of participation, the scope of peer support (non-clinical, supportive role), and available referral options for professional care. This ensures responders understand that peer support is not a substitute for therapy but a bridge to additional resources if needed.

Another ethical consideration is role clarity and competence. Peer supporters receive structured training to avoid overstepping into clinical territory and are provided with supervision or consultation pathways for complex cases. Programs also implement safeguards to prevent peer supporter burnout, such as regular debriefings and access to mental health resources for those providing support.

10. References

SAMHSA Disaster Technical Assistance Center. (2021). Peer support for first responders and disaster workers. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/dtac

Substance Abuse and Mental Health Services Administration. (2022). First responder mental health and wellness programs. U.S. Department of Health and Human Services. https://www.samhsa.gov

U.S. Department of Justice. (2015). Final report of the President's Task Force on 21st Century Policing. Office of Community Oriented Policing Services. https://cops.usdoj.gov

U.S. Department of Justice. (2017). Law Enforcement Mental Health and Wellness Act of 2017. Public Law No: 115-113. https://www.congress.gov

Resource 3

1. Title of the Best Practice

Nature-Led Community Resilience (NLCR) Toolkit - AU

2. Related Training Module

Module 3 - Psychological First Aid

3. Context and Background

The Nature-Led Community Resilience (NLCR) Toolkit originates from Victoria, Australia, and was developed by the Arthur Rylah Institute for Environmental Research in collaboration with the State of Victoria's Department of Energy, Environment and Climate Action. It was created in response to the increasing frequency and severity of disasters such as bushfires, floods, and storms in the region, which highlighted the need for approaches that support both human and ecological recovery.

The toolkit is designed to help communities and organisations integrate nature-based solutions into disaster preparedness and recovery, emphasizing the reciprocal relationship between people and nature—"*people healing nature and nature healing people*." It provides practical guidance, templates, and case studies to implement activities like nature connection walks, ecological restoration, and cultural engagement with Country, all of which aim to foster psychological safety and resilience. The approach is trauma-informed and aligns with the five elements of Psychological First Aid: safety, calm, connection, agency, and hope.

4. Objectives of the Practice

The main objectives of the NLCR Toolkit are to strengthen community resilience to disasters by integrating nature-based solutions into recovery and preparedness efforts, while simultaneously supporting psychosocial well-being. The toolkit aims to help communities and professionals reconnect with natural environments as a means of fostering calm, hope, and social connectedness, which are also core principles of Psychological First Aid (PFA). By **encouraging activities such as ecological restoration, nature walks, and cultural engagement with landscapes, the NLCR approach seeks to promote both environmental recovery and human mental health after crises**.

The problems it addresses include the growing mental health burden following disasters, such as anxiety, trauma, and social disconnection, as well as the ecological degradation that often accompanies these events. Traditional disaster recovery efforts tend to focus on infrastructure and economic rebuilding, leaving psychosocial recovery and environmental restoration underprioritized. The NLCR Toolkit responds to this gap by offering practical guidance for interventions that simultaneously heal people and ecosystems, creating a holistic recovery process that benefits both communities and the environment.

5. Description of the Practice

The process begins with engaging local communities, emergency management agencies, and environmental organisations to **identify disaster impacts on both people and ecosystems**. Facilitators use participatory workshops and surveys to understand psychosocial needs, cultural values, and ecological priorities.

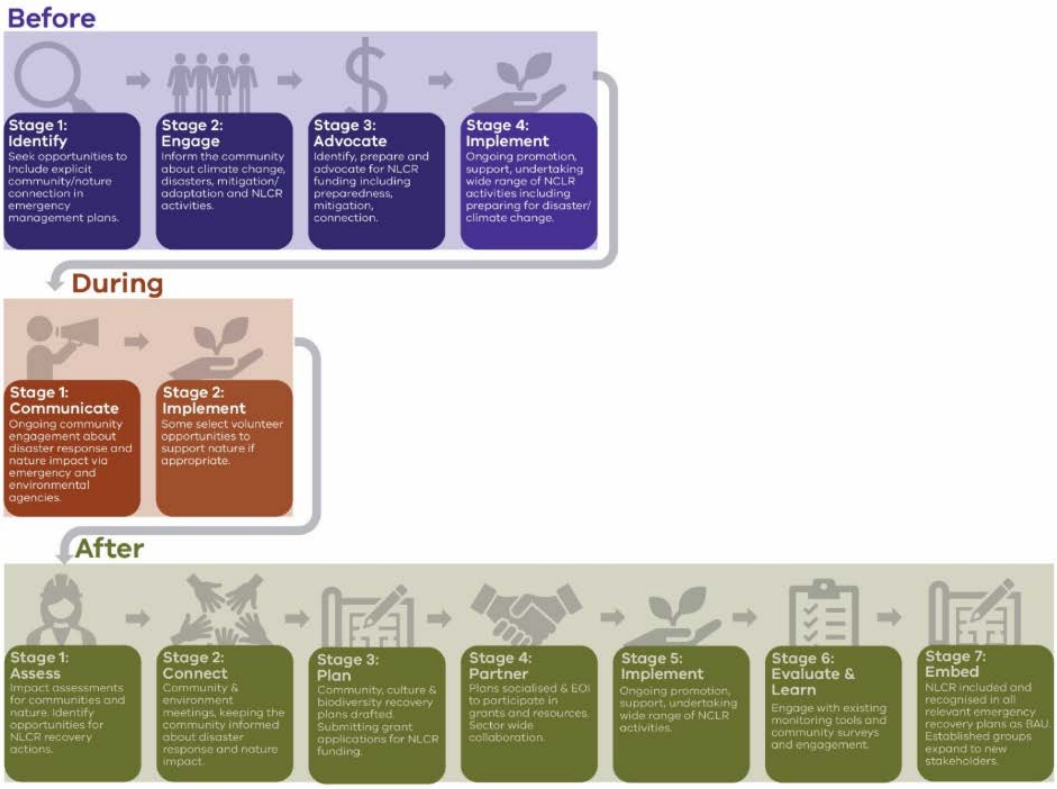
Stakeholders collaboratively design interventions that restore natural environments while promoting mental well-being. Examples include tree planting, habitat restoration, nature walks, and cultural connection activities with Indigenous knowledge holders (in case of Australia).

The activities are structured to align with **trauma-informed care and Psychological First Aid principles** — safety, calm, connectedness, self-efficacy, and hope. Facilitators ensure that participants feel safe, supported, and empowered during activities.

Communities carry out the planned activities, such as guided nature walks, ecological restoration projects, and group reflection sessions. These activities provide opportunities for social connection, stress reduction, and empowerment.

The program **includes ongoing evaluation of both ecological and psychosocial outcomes**. Surveys, interviews, and ecological indicators (e.g., biodiversity recovery) are used to measure success and inform improvements.

Step-by-Step:



Before a Disaster

Stage 1 – Identify

In this stage, coordinating agencies and community leaders begin identifying opportunities to embed nature-connection and community resilience within emergency-management plans. Step 1 matches this by initiating partnerships, mapping key actors (local government, Indigenous groups, NGOs), and defining shared goals for nature-based recovery.

Stage 2 – Engage

Here, facilitators engage the community to explore experiences, values, and ecological priorities through participatory workshops and surveys. This corresponds to the engagement phase where psychosocial and environmental needs are jointly identified.

Stage 3 – Advocate

Advocacy in the NLCR context involves co-creating and promoting project ideas that connect ecosystem restoration with community well-being. It involves collaboratively co-designing a portfolio of actions (e.g., habitat restoration, cultural activities) and preparing proposals for potential funding or policy support.

Stage 4 – Implement

This pre-disaster implementation focuses on planning readiness activities—training, resource allocation, and risk management. It aims at detailing safety protocols, scheduling, logistics, and ensuring trauma-informed structures are in place before any on-ground work begins.

During a Disaster

Stage 1 – Communicate

During an emergency, the priority is communication and coordinated readiness. Step 5 fits here by strengthening community capacity—training facilitators, volunteers, and partners to safely support environmental and psychosocial initiatives once conditions allow.

Stage 2 – Implement

When conditions permit, select volunteer or restorative activities can proceed (for example, monitoring nature impacts or providing low-risk ecological support). This corresponds directly to this implementation, ensuring that community-led actions are safe, supportive, and grounded in trauma-informed care.

After a Disaster

Stage 1 – Assess

Post-disaster assessment focuses on documenting both ecological and psychosocial impacts. It can be a mixed-method evaluation—surveys, interviews, and ecological indicators—to learn from outcomes and guide adaptation.

Stage 2–5 (Connect → Plan → Partner → Implement)

These middle "After" stages represent the cycle of community reconnection, joint planning, partnership building, and ongoing activity delivery.

Stage 6 – Evaluate & Learn and Stage 7 – Embed

Finally, the process culminates in formal evaluation and institutionalization. The last stage corresponds to embedding NLCR approaches into policy, municipal recovery frameworks, and long-term community practice—ensuring that nature-led recovery becomes business-as-usual and scalable to new contexts.

6. Outcomes and Impact

The Nature-Led Community Resilience Toolkit has shown promising results in enhancing both psychosocial well-being and ecological recovery after disasters, though most evidence is qualitative and based on pilot projects in Victoria, Australia. Community feedback indicates that nature-based activities—such as habitat restoration, guided nature walks, and cultural engagement with Indigenous knowledge—helped participants feel calmer, more connected, and empowered during recovery.

Evaluation reports highlight that participants experienced **reduced stress and anxiety, improved social cohesion, and a stronger sense of agency in rebuilding their communities**. Ecological benefits, such as increased biodiversity and restored green spaces, also contributed to a **sense of purpose and collective achievement**, which reinforced psychological resilience. While quantitative data is limited, early assessments suggest that integrating nature-based interventions into disaster recovery can complement traditional mental health approaches and provide a low-cost, culturally adaptable strategy for resilience-building.

7. Lessons Learned and Success Factors

The success of the toolkit can be attributed to the **co-design approach** that ensured strong community ownership by involving local residents, Indigenous knowledge holders, professionals and environmental experts in planning and implementation. This participatory process built trust and cultural relevance, which increased engagement. Second, the **integration of nature-based activities with psychosocial principles** created a dual benefit: restoring ecosystems while promoting mental health through connection, calm, and hope. The use of practical tools—such as activity templates, evaluation guides, and cultural engagement protocols—also contributed to smooth implementation. Additionally, partnerships between government agencies,

NGOs, and mental health professionals provided technical expertise and resources, ensuring sustainability.

However, the practice faced challenges. Limited funding and resources initially constrained the scale of activities, which was mitigated by leveraging volunteer networks and in-kind contributions from local organisations. Another challenge was community skepticism, as some participants prioritised infrastructure recovery over ecological restoration. This was addressed through education campaigns highlighting the mental health and resilience benefits of nature-based recovery. Finally, logistical issues such as coordinating diverse stakeholders and ensuring safety during outdoor activities were managed through clear governance structures and risk management plans.

8. Transferability and Adaptability

This toolkit can be adapted to other contexts or regions by maintaining its core principles—nature-based recovery, community co-design, and psychosocial support—while tailoring the approach to local cultural, ecological, and disaster realities.

For areas exposed to wildfires: Adaptations should center on reforestation using fire-resistant native species and habitat restoration to create natural firebreaks around settlements. The community co-design element should involve local volunteer groups and traditional ecological knowledge holders co-designing the planting and maintenance schedule for maximum fire resilience.

For regions with high flood/storm-surge risk: The focus shifts to community-managed coastal ecosystem restoration projects (e.g., mangrove or sea-grass planting) to act as natural buffers against storm energy and erosion.

For Areas Facing Recurrent Drought and Desertification: Nature-based recovery can include establishing communal micro-gardens (e.g., using water-efficient techniques like keyhole gardens) to promote local food security and water conservation using native, drought-tolerant plants.

For densely populated urban areas (Acute Hazards): Adaptation can involve transforming underutilized dense spaces into 'pocket parks' or 'urban oases' to mitigate the heat island effect and improve air and water quality.

To ensure cultural relevance, adaptation should involve local stakeholders and residents, integrating traditional ecological practices and community rituals into recovery activities. In urban settings, where access to wilderness is limited, the approach could pivot to green infrastructure projects—such as rooftop gardens, urban parks, and community green spaces—while still embedding Psychological First Aid principles like safety, calm, and connectedness.

Finally, partnerships with local NGOs, mental health organisations, and environmental agencies are essential for resource mobilization and sustainability. Digital tools, such as mobile apps for guided nature activities or virtual peer support groups, can help scale the model in regions with limited in-person access.

9. Ethical Considerations

The program follows trauma-informed care principles, ensuring that activities do not retraumatise participants. This includes providing options for participation, respecting cultural practices, and allowing individuals to opt out at any time. When Indigenous knowledge was incorporated in Australia, strict ethical protocols require obtaining permission from knowledge holders and acknowledging intellectual property rights were required.

Key operational practices include:

Voluntary Participation and Choice: Ensuring activities are designed with a low barrier to entry, providing clear options for involvement, and allowing individuals to opt in or out at any time without pressure or penalty.

Intercultural dialogue: Actively seeking to understand and respect diverse cultural practices (including mourning rituals and community gathering norms), beliefs, and local histories of trauma to ensure the intervention is culturally safe.

Equity and accessibility: Designing both the physical activities and the outreach to ensure that support and resources are distributed fairly and are accessible to individuals of all abilities and backgrounds (e.g., considering physical, linguistic, and financial barriers).

Formal engagement and consent: Obtaining explicit permission from knowledge holders or their representative governing bodies before any knowledge is shared, adapted, or utilized in the program design.

Intellectual property and benefit sharing: Formally acknowledging intellectual property and cultural ownership rights over the knowledge, ensuring proper attribution is given and transparent benefit-sharing arrangements are negotiated and agreed upon.

Referral to community resources and mental health services: establishment of a strict, immediate referral pathway for participants presenting with acute distress or elevated mental health risk. All staff and facilitators must be trained in recognizing crisis indicators and the appropriate, non-coercive procedures for making external referrals. This includes maintaining an up-to-date and easily accessible list of local and national mental health resources, including 24/7 crisis lines and suicide prevention services, ensuring participants are provided with clear, confidential contact information, and understanding the legal and ethical limits of their support role within the scope of the nature-led intervention.

Finally, all activities should maintain strict protocols for Data Privacy and Confidentiality to protect personal information, and transparent Accountability Mechanisms are established to address participant feedback, refer to mental health services if necessary and resolve ethical concerns quickly.

10. References

Arthur Rylah Institute for Environmental Research. (2022). Nature-led community resilience toolkit: Building resilience through nature-based solutions. Department of Energy, Environment and Climate Action, State of Victoria. https://www.ari.vic.gov.au

Department of Energy, Environment and Climate Action. (2022). Nature-led recovery: Supporting communities and ecosystems after disasters. Victorian Government. https://www.energy.vic.gov.au

Lee, K, Lamont, A, van Eeden, L., Whiteford, C. and Hames, F. (2024). The Nature and community-led approach to disaster resilience: Toolkit. Published Report. Department of Energy, Environment and Climate Action, Heidelberg, Victoria.

Resource 4

1. Title of the Best Practice

Blue Light Programme - UK

2. Related Training Module

Module 3 – Psychological First Aid

3. Context and Background

The Blue Light Programme was launched in England in March 2015 by the mental health charity Mind, with financial support from the UK Cabinet Office through a £4 million LIBOR fund. It was developed in response to alarming research findings showing that **nine out of ten emergency service staff and volunteers in England had experienced stress, low mood, or poor mental health at some point in their careers.** These issues were strongly linked to the nature of their work, which involves repeated exposure to traumatic incidents, heavy workloads, and irregular hours. However, the research also revealed that workload pressures and management demands were even greater triggers for poor mental health than trauma exposure itself.

The programme targeted personnel across all "blue light" emergency services, including police, fire, ambulance, and search and rescue staff and volunteers. Its primary aim was to address the high prevalence of mental health problems in these professions, reduce stigma, and improve access to mental health support. The initiative was particularly urgent because emergency responders were found to be twice as likely as the general workforce to attribute their mental health problems to work-related factors. Additionally, stigma and lack of awareness about available support prevented many from seeking help.

Geographically, the programme was implemented across England and Wales, with a strong emphasis on local delivery through partnerships with regional Mind branches and emergency service organizations. It was structured around five key strands: tackling stigma and discrimination, embedding workplace wellbeing, increasing resilience, providing targeted advice and support, and improving pathways to services. **These strands included activities such as anti-stigma campaigns, resilience training, peer support networks, and the creation of a dedicated Blue Light Infoline for confidential advice**.

4. Objectives of the Practice

The main objectives of the Blue Light Programme were to improve the mental health and well-being of emergency service staff and volunteers in England and Wales by addressing systemic and cultural barriers to support. Specifically, the programme aimed to:

- **Tackle stigma and discrimination**: Many emergency service workers reported that mental health issues were not openly discussed within their organisations. The programme sought to normalize conversations about mental health and reduce stigma through targeted **anti-stigma campaigns, public pledges from**

employers, and the creation of Blue Light Champions to promote awareness in the workplace.

- **Promote workplace well-being**: The programme aimed to integrate mental health support into organisational culture by **providing training for managers and leaders, developing webinars, and promoting policies that prioritize staff well-being**.
- **Increase resilience:** Recognising the high-stress nature of emergency service roles, the programme introduced **resilience-building initiatives**, including a tailored six-week resilience course and resources to help staff cope with the psychological demands of their work.
- **Provide targeted advice and support:** To ensure easy access to help, the programme established the **Blue Light Infoline**, distributed mental health resources, and created referral frameworks for those needing more intensive care.
- **Improve pathways to services and support**: The programme trained peer supporters and developed local mental health networks to strengthen coordination between emergency service employers and mental health providers.

5. Description of the Practice

The programme began with a comprehensive research phase led by Mind, which surveyed thousands of emergency service staff and volunteers across England and Wales. This research identified the scale of mental health challenges, stigma, and barriers to support within the sector. The findings shaped the programme's design and priorities.

The initiative was funded through a £4 million LIBOR fund provided by the UK Cabinet Office. Mind partnered with emergency service organizations, local Mind branches, and mental health professionals to ensure national reach and local delivery.

To tackle stigma, the programme launched public campaigns, and internal awareness drives within emergency services. This included:

- Blue Light Champions: Volunteers from within emergency services trained to promote mental health awareness and act as peer supporters.
- Employer Pledges: Organisations signed commitments to improve mental health culture.
- Communication Tools: Posters, videos, and social media campaigns to normalise mental health conversations.

The programme delivered specialised training for:

- Managers: To help them recognise signs of poor mental health, respond appropriately and implement first-aid psychological techniques.
- Staff and volunteers: Through webinars, workshops, and resilience-building courses (including a six-week resilience program).
- Peer support networks: Training staff to provide informal support, first-aid psychological techniques and signpost resources.

6. Outcomes and Impact

The Blue Light Programme achieved significant results in improving mental health awareness and support among emergency service staff and volunteers in the UK. According to Mind's evaluation, the programme ran in two phases: the first from 2015 to 2019, and the second from 2020 to 2023 in response to the COVID-19 pandemic.

By the end of the programme, 93% of UK emergency services had signed the Mental Health at Work Commitment, signaling a strong cultural shift toward prioritizing mental health. Also nearly 10,000 line managers and peer supporters were trained to recognise and respond to mental health issues within their teams. Thousands of staff also became Blue Light Champions, promoting awareness and reducing stigma in their workplaces.

The programme launched Blue Light Together, a dedicated online hub for mental health resources, which received over 50,000 visits. This platform provided tailored advice, self-help tools, and signposting to further support.

Research conducted during the pandemic revealed that 69% of emergency responders reported worsening mental health, highlighting the continued need for such initiatives. However, 35% felt their organizations had prioritised mental health during this period, suggesting progress in organisational attitudes.

Testimonials from participants indicated that the programme encouraged more open conversations about stress and mental health, helping individuals feel supported and less isolated.

7. Lessons Learned and Success Factors

The success of the Blue Light Programme was driven by several interconnected factors that addressed both cultural and structural barriers within emergency services. One of the most significant contributors was its evidence-based design. The programme was launched after research revealed that nearly nine in ten emergency service workers had experienced stress or poor mental health during their careers, and that stigma and lack of support were major obstacles to seeking help. This data-driven approach ensured that the interventions were relevant and targeted at the real needs of the workforce.

Another key factor was the comprehensive nature of the programme. Rather than focusing on a single solution, it combined multiple strategies: anti-stigma campaigns, resilience training, workplace well-being policies, peer support networks, and direct advice services such as the Blue Light Infoline. This holistic approach allowed the programme to address both immediate mental health needs and long-term cultural change. The introduction of Blue Light Champions—staff members trained to promote mental health awareness—was particularly effective in normalising conversations about mental health and creating peer-led support systems within teams.

Partnerships also played a crucial role. Mind worked closely with local Mind branches, emergency service organizations, and mental health professionals, ensuring that the programme had national reach while maintaining local relevance. This collaborative model built trust among emergency service staff and increased engagement with the programme's resources.

However, the programme faced several challenges. Stigma and cultural resistance remained significant barriers, especially in hierarchical organisations where admitting vulnerability was often perceived as weakness. To overcome this, the programme implemented visible leadership pledges, awareness campaigns, and training for managers to foster a supportive environment. Another challenge was low awareness of available resources in the early stages. This was addressed by expanding communication efforts, launching the Blue Light Infoline, and creating an online hub for mental health resources, which significantly improved accessibility.

Funding and sustainability were also concerns, given the scale of the programme and the need to provide free, high-quality services. These were mitigated through government funding from the LIBOR fund and strategic partnerships that shared costs and responsibilities. Finally, promoting mental health policies into organisational structures required strong leadership buy-in, which was achieved through targeted engagement and public commitments from emergency service employers.

8. Transferability and Adaptability

The Blue Light Programme offers a flexible model that can be adapted to other contexts or regions by maintaining its core principles while tailoring the approach to local needs. At its heart, the programme focuses on reducing stigma, improving access to mental health support, and embedding well-being into organisational culture. These principles are universally relevant and can be applied to any high-stress profession or emergency response system.

To adapt the programme elsewhere, the first step would be to conduct a local needs assessment to understand the specific stressors, cultural attitudes toward mental health, and existing support gaps. For example, in countries where emergency services are decentralised or volunteer-based, the programme could partner with local NGOs or community organisations to deliver training and resources.

The multi-strand approach of the Blue Light Programme—combining awareness campaigns, resilience training, peer support networks, and direct advice services—can be replicated in other sectors such as healthcare, humanitarian aid, or disaster response. For instance, during health crises like pandemics, a similar model could support doctors, nurses, and paramedics who face comparable pressures to emergency responders.

Technology can play a key role in adaptation. In regions with limited physical infrastructure, online platforms and helplines can provide confidential support and training. Where internet access is restricted, mobile counseling units or partnerships with local clinics could serve as alternatives. Additionally, peer support systems and ‘mental health champions’ can be introduced in any organisational setting to normalise conversations about mental health and reduce stigma.

9. Ethical Considerations

The Blue Light Programme incorporated several ethical considerations to ensure that participants felt safe and supported when engaging with mental health services. One of the most critical aspects was confidentiality. All services provided through the programme, including the Blue Light Infoline and counseling sessions, were designed to be completely confidential. This meant that no information was shared with

employers or colleagues without the individual's explicit consent. This commitment to privacy was essential in reducing stigma and encouraging emergency service staff to seek help without fear of professional repercussions.

Before accessing any support services, participants were clearly informed about the nature of the service, what it involved, and their rights regarding data protection and privacy. They were also made aware of the limits of confidentiality, such as situations involving immediate risk of harm to themselves or others, in line with professional and legal standards. This transparency ensured that individuals could make informed decisions about their participation.

The programme also emphasised non-discrimination and cultural sensitivity, ensuring that all emergency service staff and volunteers—regardless of role, rank, or background—had equal access to support. Training for managers and peer supporters included guidance on respecting diversity and maintaining ethical boundaries when offering mental health assistance.

10. References

Mind. (2015). Blue Light Programme: Supporting the mental health of emergency services staff and volunteers. Mind. Retrieved from https://www.mind.org.uk/

Mind. (2020). Blue Light Programme evaluation report. Mind. Retrieved from https://www.mind.org.uk/

Mind. (2023). Blue Light Together: Mental health support for emergency responders. Mind. Retrieved from https://www.bluelighttogether.org.uk/

Resource 5

1. Title of the Best Practice

Model of psychological first aid for non–mental health trained public health personnel: The Johns Hopkins RAPID-PFA (USA)

2. Related Training Module

Module 3 - Psychological First Aid.

3. Context and Background

The RAPID-PFA (Psychological First Aid) model, developed by the Johns Hopkins Center for Public Health Preparedness, is a structured, evidence-informed approach designed to provide immediate psychological support to individuals affected by disasters and critical incidents. Developed to promote emotional stabilisation, resilience, and adaptive coping, this model is widely applied in contexts such as natural disasters, armed conflicts, and public health emergencies. **It was designed to be accessible to non-mental health professionals, including public health workers, volunteers, and first responders.**

The RAPID-PFA model stands out among psychological first aid approaches due to its structured, evidence-informed framework and its emphasis on functionality, triage, and future orientation**. It was designed to address the surge in psychological distress following disasters, especially in contexts where mental health professionals are scarce.** Unlike traditional psychological first aid models that often focus broadly on emotional support and stabilisation, RAPID-PFA introduces a systematic five-step process—Rapport, Assessment, Prioritization, Intervention, and Disposition—that guides non-specialist responders through a clear and replicable method of crisis intervention.

One of the most distinctive features of RAPID-PFA is its **triage-based approach**. The model emphasizes the need to assess and prioritize individuals based on their functional capacity and level of distress. This allows responders to allocate limited resources efficiently and ensure that those in greatest need receive timely support. Traditional PFA models may offer general support to all affected individuals, but RAPID-PFA integrates a clinical logic of prioritisation, making it particularly effective in large-scale emergencies.

Another unique aspect is its focus on **restoring functional capacity**. Rather than aiming for therapeutic resolution, RAPID-PFA seeks to help individuals regain their ability to perform basic tasks and make decisions. The model also incorporates reflective listening and guided narrative techniques during the assessment phase, allowing survivors to express their experiences in a non-clinical, supportive environment. This contrasts with more diagnostic or therapeutic approaches found in other models, which may not be suitable for non-specialist responders.

Furthermore, RAPID-PFA places a strong emphasis on **follow-up and disposition**. It recognises that psychological first aid is not a one-time interaction but a process that

may require multiple contacts and referrals. The disposition phase ensures that survivors are connected to appropriate long-term resources, whether through family, community services, or professional care.

4. Objectives of the Practice

The RAPID-PFA model was developed as a practical and scalable solution to the psychological challenges that arise during and after disasters. **Its primary objective is to provide immediate emotional support to individuals affected by traumatic events, helping them stabilize psychologically, regain a sense of control, and begin the process of recovery**.

Some specific objectives of the model are:

- To promote emotional **stabilisation**.
- To foster **resilience**, normalise stress responses and **adaptive coping strategies** (e.g., practical tools and techniques that empower individuals to manage their emotions and make informed decisions).
- To connect people to their existing support **networks**.
- To allow a **rapid triage** and prioritisation of needs and resources.

5. Description of the Practice

The model is designed to be implemented quickly and efficiently, even in chaotic or resource-limited environments, making it especially valuable in large-scale emergencies. It can be delivered by trained professionals or volunteers, including public health workers, first responders, and community members. This flexibility makes it a vital tool in addressing the shortage of mental health professionals during crises and ensuring that psychological support reaches those who need it most.

The RAPID-PFA model consists of five sequential stages:

1. **Rapport Building**

The responder should first establish trust and psychological safety through empathetic communication. This means introducing him/herself, explain his/her role, and create a calm, supportive environment.

2. **Assessment**

Then, he/she should evaluate the individual's immediate needs, emotional state, and potential risk factors. This includes observing behavior and asking open-ended questions to identify distress levels.

3. **Prioritisation**

The responder should determine who requires urgent attention based on severity of symptoms, vulnerability (e.g., children, older people), and exposure to trauma.

4. **Intervention**

He/She should provide practical and emotional support. Normalize stress reactions, teach coping strategies, and connect individuals to resources and social support systems.

5. Disposition

Finally, the responder should ensure continuity of care by referring individuals to mental health professionals when necessary, offering follow-up information, and confirming the presence of a support network.

Some key principles guide this intervention like the respect of autonomy, avoiding forcing disclosure; focus on immediate needs and stabilisation rather than deep psychological processing, and, sensibility towards diverse cultural and situational contexts.

The official training is delivered as a 1-day (6-hour) workshop, includes lectures, PowerPoint presentations, and role-play exercises (e.g., reflective listening triads). Participants practice each RAPID step in small groups to build confidence and competence.

6. Outcomes and Impact

The RAPID-PFA model has undergone extensive evaluation to determine its effectiveness in training non–mental health professionals to deliver psychological first aid in disaster contexts. The results consistently demonstrate positive outcomes across several key domains:

- Participants showed statistically significant improvements in their understanding of psychological first aid principles and techniques after completing the RAPID-PFA training.The training effectively imparted the core knowledge needed to apply PFA in real-world crisis situations.
- Trainees reported increased confidence in their ability to deliver psychological support. There was a marked improvement in self-perceived resilience, suggesting that participants felt more capable of managing their own stress while helping others.
- Evaluation instruments used in the studies demonstrated high internal consistency, with Cronbach alpha coefficients ranging from 0.87 to 0.90, indicating reliable measurement of knowledge, self-efficacy, and resilience.
- In a randomized controlled trial among nursing students in Tunisia, improvements in perceived competencies, disaster preparedness, and helping capacity were sustained over time—measured at 1- and 3-months post-training. The effect size was substantial (Cohen's d = 0.8), indicating a strong and lasting the training intervention.
- Over 1,500 participants received the RAPID-PFA training in a 1-day workshop format. Participants reported that the training enhanced their preparedness to respond to real-world crises and improved their ability to recognize psychological distress in others

The model proved to be scalable, cost-effective, and accessible to a wide range of public health personnel and community responders.

7. Lessons Learned and Success Factors

RAPID-PFA was designed to be non-intrusive and culturally adaptable, allowing it to be used across diverse populations and settings. The training format—delivered in

a **6-hour workshop**—was found to be **scalable, accessible, and effective** for a wide range of public health personnel, first responders, and community volunteers.

The success of the RAPID-PFA model in disaster response is also attributed to its structured and competency-based design made it accessible to non–mental health professionals, including public health workers, volunteers, and first responders. The model's five-step framework—Rapport, Assessment, Prioritization, Intervention, and Disposition—provides a clear and replicable process that could be taught in a single-day workshop.

Another major contributor to its success was the evidence-informed curriculum, which was validated through content studies involving over 1,500 participants. These studies showed statistically significant improvements in participants' knowledge, perceived self-efficacy, and confidence in their own resilience. The internal consistency of the evaluation tools was high, with Cronbach alpha coefficients ranging from 0.87 to 0.90, indicating reliable measurement of training outcomes.

The model also benefites from its flexibility and cultural adaptability. It was designed to be implemented in diverse settings, including underserved and access-compromised areas, where traditional mental health services were unavailable. By training local responders with cultural knowledge and credibility, the model helped bridge gaps in mental health service delivery during crises.

Regarding the challenges, one significant barrier reported was the shortage of trained mental health professionals, especially in rural or disaster-affected regions. This was addressed by empowering non-specialists through targeted training, thereby expanding the behavioral health surge capacity of communities. Another challenge was the lack of standardised implementation protocols across different PFA models. The RAPID-PFA model overcame this by integrating consensus guidelines and structural modeling to refine its componential infrastructure. This ensured consistency in training and delivery, even when scaled across various populations and settings.

Additionally, some providers reported difficulties in applying the model in real-time crisis situations due to emotional overwhelm or logistical constraints. To mitigate this, the training included role-play exercises and reflective listening practice, which helped participants internalize the techniques and build confidence in their ability to respond effectively (Wang et al., 2024).

8. Transferability and Adaptability

It has been successfully applied in a range of disaster scenarios, including natural disasters, armed conflicts, and public health emergencies. Its non-intrusive and culturally sensitive design allows it to be tailored to specific regional and cultural contexts. In resource-limited regions, the model has been implemented by community health workers and local volunteers, demonstrating its scalability and relevance in low-resource environments.

9. Ethical Considerations

The RAPID-PFA model incorporates several ethical considerations to ensure that psychological support is delivered responsibly and respectfully, even in high-stress

disaster environments. One of the most important principles is respect for autonomy, which is operationalised through, verbally, obtaining informed consent before engaging in any intervention. Although the model is designed for rapid application, providers are trained to explain their role clearly, outline the purpose of the interaction, and confirm that the individual is willing to participate. This process is adapted to the context, often using simple, clear language to accommodate individuals who may be in shock or experiencing cognitive overload.

RAPID-PFA emphasises that any personal information shared during the interaction must be kept private unless disclosure is necessary to prevent imminent harm to the individual or others. Providers are instructed to avoid unnecessary note-taking in the field and to share information only with authorised personnel involved in the individual's care.

Interventions are designed to be non-intrusive and supportive, avoiding any pressure to disclose traumatic details. Providers are trained to recognise cultural norms and adapt their communication style accordingly, ensuring that the interaction does not inadvertently cause distress or violate local customs. Additionally, the model discourages pathologising normal stress reactions, focusing instead on practical coping strategies and empowerment.

Finally, ethical practice within RAPID-PFA includes referral and continuity of care. If an individual exhibits signs of severe psychological distress or risk of harm, the provider is ethically obligated to facilitate access to appropriate mental health services. This ensures that the limits of the provider's competence are respected and that individuals receive the level of care they need.

10. References

Despeaux, K. E., Lating, J. M., Everly, G. S., Sherman, M. F., & Kirkhart, M. W. (2019). A randomized controlled trial assessing the efficacy of group psychological first aid (PFA). Journal of Nervous and Mental Disease, 204(3), 233–235.

Everly, G. S., Barnett, D. J., & Links, J. M. (2012). The Johns Hopkins model of psychological first aid (RAPID-PFA): Curriculum development and content validation. International Journal of Emergency Mental Health, 14(2), 95–105.

Everly, G. S., McCabe, O. L., Semon, N. L., Thompson, C. B., & Links, J. M. (2014). The development of a model of psychological first aid for non–mental health trained public health personnel: The Johns Hopkins RAPID-PFA. Journal of Public Health Management and Practice, 20(Suppl 5), S24–S29. https://doi.org/10.1097/PHH.0000000000000065

Wang, L., Norman, I., Edleston, V., Oyo, C., & Leamy, M. (2024). The effectiveness and implementation of psychological first aid as a therapeutic intervention after trauma: An integrative review. Trauma, Violence, & Abuse, 25(4), 2638–2656. https://doi.org/10.1177/15248380231221492

RESILIENT RESPONDERS

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