



Resilient Responders Best Practices Repository for Module 6

Prepared by IED

Resource 1

1. Title of the Best Practice

Critical Incident Stress Debriefing (CISD) Protocol – Applied in Fire and Rescue Services (Canada & UK)

2. Related Training Module

Module 6 – Post-Disaster Mental Health Support Systems

3. Context and Background

The Critical Incident Stress Debriefing (CISD) protocol was developed by the International Critical Incident Stress Foundation (ICISF) in the 1980s and has since been implemented across emergency and rescue services in Canada, the United Kingdom, and the United States.

It was designed as an early psychological intervention following traumatic incidents such as major fires, floods, earthquakes, and mass-casualty accidents.

Firefighters, paramedics, and police personnel regularly use this structured model to process operational stress and prevent post-traumatic stress injuries.

Field of Application:

Fire and Rescue Services, Paramedic Units, Police Forces – post-incident response (within 24–72 hours).

4. Objectives of the Practice

- To provide a structured approach for responders to process traumatic experiences.
- To reduce the risk of acute stress reactions developing into long-term trauma.
- To enhance team communication, peer trust, and psychological resilience



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5. Description of the Practice

The CISD is a seven-phase, peer-led group debriefing process facilitated by trained mental health professionals and peer supporters:

1. **Introduction** – Explain purpose, confidentiality, and voluntary participation.
2. **Fact Phase** – Participants describe what happened from their perspective.
3. **Thought Phase** – Members share initial thoughts or reactions.
4. **Reaction Phase** – Discussion of emotional responses.
5. **Symptom Phase** – Identification of physical or psychological symptoms.
6. **Teaching Phase** – Provide coping strategies and normalise reactions.
7. **Re-entry Phase** – Summarise, provide resources, and close the session.

Each session lasts around 1.5–2 hours, conducted within 72 hours after an incident, and includes 6–10 participants.

6. Outcomes and Impact

- Studies conducted by ICISF and fire services in Canada and the UK show reduced absenteeism and improved coping mechanisms among participants.
- Responders report feeling more supported, less isolated, and more willing to seek help.
- Follow-up surveys highlight decreased emotional distress and improved morale after critical incidents.

7. Lessons Learned and Success Factors

- Success depends on trained facilitators and voluntary participation.
- Confidentiality and peer inclusion are essential.
- When applied too early (less than 24 hours), participants may resist participation due to shock.



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8. Transferability and Adaptability

- The model has been successfully adapted for healthcare, aviation, and humanitarian contexts.
- Can be implemented internationally where responder teams have established peer structures.

9. Ethical Considerations

- Confidentiality is strictly observed; no identifying data is recorded.
- Participants provide informed consent before starting the session.
- Facilitators must avoid coercion and respect cultural differences in emotional expression.

10. References

International Critical Incident Stress Foundation (ICISF). (2023). *CISM: Critical Incident Stress Management Overview*. <https://icisf.org>

Everly, G. S., & Mitchell, J. T. (1999). *Critical Incident Stress Management (CISM): A new era and standard of care in crisis intervention*. Chevron.

World Health Organization. (2011). *Psychological first aid: Guide for field workers*. WHO Press.



Resource 2

1. Title of the Best Practice

Trauma Risk Management (TRiM) Peer Support Programme – UK Fire and Rescue Services

2. Related Training Module

Module 6 – Post-Disaster Mental Health Support Systems

3. Context and Background

The Trauma Risk Management (TRiM) approach was developed by the UK Ministry of Defence in the late 1990s and has since been adopted by emergency services across the UK and Europe, including Fire & Rescue Services, Police Scotland, and NHS ambulance trusts.

TRiM is a peer-delivered psychological risk assessment and management system designed to identify, monitor, and support individuals exposed to potentially traumatic events.

Its purpose is to provide a structured, proactive model of peer support embedded within organisational culture.

Field of Application:

Fire and Rescue Services, Police Units, NHS Ambulance Trusts – across the UK and adapted in the Netherlands, Norway, and Ireland.

4. Objectives of the Practice

- To identify personnel at risk of psychological distress following critical incidents.
- To provide timely, confidential peer support and early intervention.
- To reduce stigma and promote open discussion of mental health in responder organisations.
- To build resilience and enhance long-term well-being across the workforce.



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5. Description of the Practice

The TRiM model follows a structured process:

1. Selection and Training of TRiM Practitioners:

Peer supporters are trained in trauma awareness, confidentiality, and risk identification.

Training typically lasts 2–3 days and is accredited by TRiM UK or partner organisations.

2. Post-Incident Assessment:

Within 72 hours of a traumatic incident, TRiM practitioners conduct initial assessments using standardised checklists.

3. Follow-Up Review:

A secondary review occurs within 28 days to monitor coping and identify ongoing support needs.

4. Referral Pathways:

If high-risk indicators are observed, practitioners refer individuals to professional mental health services.

5. Ongoing Peer Contact:

Peers maintain informal support to reduce isolation and normalise recovery conversations.

6. Outcomes and Impact

- Evaluation by **King's College London (Greenberg et al., 2010)** found that TRiM significantly improved help-seeking behaviour and reduced stigma among military and emergency responders.
- Fire & Rescue Services implementing TRiM report decreased sickness absence and improved morale.
- Peer feedback indicates higher trust and willingness to engage compared to traditional counselling approaches.

7. Lessons Learned and Success Factors

- Institutional endorsement and managerial support are essential for sustainability.



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- Training quality and regular refresher courses ensure consistent application.
- Challenges include maintaining confidentiality in small teams and avoiding overburdening peer supporters.

8. Transferability and Adaptability

- The model has been adapted across Europe (Netherlands, Norway, Ireland) and is compatible with EU occupational health frameworks.
- Can be integrated with other MHPSS initiatives (e.g., WHO Psychological First Aid, IASC Guidelines).

9. Ethical Considerations

- Confidentiality agreements and informed consent are mandatory.
- Peer supporters receive supervision to manage boundaries and prevent secondary trauma.
- TRiM explicitly discourages coercion or forced participation.

10. References

Greenberg, N., Langston, V., & Jones, N. (2010). Trauma Risk Management (TRiM) in the UK Armed Forces: A case study of occupational mental health practice. *Journal of Mental Health, 19*(6), 543–548.

TRiM UK. (2023). *TRiM Practitioner Training and Accreditation*. <https://www.trim-training.co.uk>



Resource 3

1. Title of the Best Practice

Community-Based Mutual Aid Networks for Post-Disaster Recovery – Central Italy (2016 Earthquakes)

2. Related Training Module

Module 6 – Post-Disaster Mental Health Support Systems

3. Context and Background

After the devastating earthquakes that struck Central Italy between August 2016 and January 2017, local communities, volunteers, and NGOs mobilised to support both material and emotional recovery.

In regions such as Amatrice, Norcia, and L'Aquila, citizens spontaneously formed mutual aid networks to share resources, rebuild social bonds, and address the psychological impacts of displacement and loss.

These initiatives were later supported by organisations including Caritas Italiana, Protezione Civile, and local municipalities, evolving into structured community recovery hubs offering peer and psychosocial support.

4. Objectives of the Practice

- To promote emotional recovery and social cohesion after disasters.
- To reduce isolation and stress among affected citizens and volunteer responders.
- To empower local communities to take part in their own psychosocial recovery.
- To complement professional mental health services with peer- and community-based initiatives.

5. Description of the Practice

The mutual aid networks followed a structured, community-driven process:

1. **Initial Mobilisation:** Within weeks of the earthquake, citizens and volunteers created informal support groups in temporary shelters and community



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centres.

2. **Facilitation and Support:** Local NGOs (Caritas Italiana, ActionAid) trained community facilitators to lead regular meetings focused on emotional expression, stress management, and practical problem-solving.
3. **Integration with Public Services:** Municipalities and Protezione Civile provided logistical support and linked groups with health and social services.
4. **Community Recovery Hubs:** By 2018, some of these groups became permanent local centres for volunteer coordination and social activities, strengthening long-term community resilience.

6. Outcomes and Impact

According to Caritas Italiana (2018) and the Politecnico di Milano (2024) study, communities participating in mutual aid initiatives demonstrated:

- Higher levels of perceived resilience and community belonging.
- Reduced emotional distress and social withdrawal.
- Faster reintegration into daily routines compared to non-participating communities.

These networks also supported informal psychosocial monitoring and improved coordination between citizens and professional responders.

7. Lessons Learned and Success Factors

- Trust and local ownership were key to success; initiatives led by residents were more sustainable.
- Collaboration between professionals (psychologists, social workers) and volunteers enhanced credibility and effectiveness.
- Challenges included maintaining participation over time and balancing emotional support with practical recovery tasks.

8. Transferability and Adaptability

- The model is highly transferable to other EU regions with strong civil protection and volunteer systems.



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- It can be adapted to rural and urban settings and to other disaster types (floods, wildfires).
- Offers a model for integrating community resilience and psychosocial recovery in EU disaster management frameworks.

9. Ethical Considerations

- Confidentiality was respected within each group; no records of personal stories were kept.
- Participation was voluntary and consent was obtained for all group activities.
- Facilitators received supervision to manage emotional boundaries and avoid secondary trauma.

10. References

Caritas Italiana. (2018). *Post-earthquake community rebuilding report – Central Italy case study*. Caritas Publications.

Politecnico di Milano. (2024). *Learning lessons from disaster recovery: Local and community participation in post-disaster reconstruction in Central Italy*. Polimi Digital Repository.

Protezione Civile Italiana. (2019). *Rapporto annuale sulla gestione del post-sisma 2016–2017*. Roma: Dipartimento della Protezione Civile.



Resource 4

1. Title of the Best Practice

Establishing Referral Pathways for Mental Health and Psychosocial Support – Greece (Hellenic Red Cross & Civil Protection Model)

2. Related Training Module

Module 6 – Post-Disaster Mental Health Support Systems

3. Context and Background

In the aftermath of major disasters in Greece including the 2018 Attica wildfires and the 2023 Thessaly floods the need for coordinated mental health and psychosocial support (MHPSS) became critical.

The Hellenic Red Cross (HRC), in collaboration with the Ministry for Climate Crisis and Civil Protection, adopted the Inter-Agency Standing Committee (IASC) Guidelines to establish structured referral pathways connecting first responders, social workers, psychologists, and health services.

These referral systems ensure that individuals in distress, identified during emergency operations or through community networks, receive timely and appropriate mental health care.

Field of Application:

Disaster-affected communities in Greece (post-wildfire and flood settings) – coordinated by Hellenic Red Cross, Civil Protection, and municipal psychosocial teams.

4. Objectives of the Practice

- To establish clear and confidential procedures for referring affected individuals to appropriate psychosocial and clinical services.
- To ensure collaboration among responders, health professionals, and community organisations.
- To reduce psychological distress and prevent long-term trauma.
- To strengthen national capacity for integrated MHPSS response.



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5. Description of the Practice

The referral system operates in four main phases:

1. Identification and Screening:

Trained field volunteers (e.g., HRC, municipal teams) identify individuals showing signs of distress using IASC assessment forms.

2. Initial Support and Mapping:

Individuals receive immediate psychological first aid (PFA) and information on available services.

Cases are logged anonymously in a referral database managed by the coordinating body (e.g., Civil Protection or HRC).

3. Referral Process:

Based on severity and needs, individuals are referred to:

- Community psychosocial support teams.
- Mental health professionals (psychiatrists, psychologists).
- Social welfare services or health centres.

Referral decisions follow the “Stepped Care Model”, ensuring proportional response.

4. Follow-Up and Feedback:

Psychosocial teams provide follow-up contact within 2–4 weeks.

Coordination meetings review progress and adjust support plans.

6. Outcomes and Impact

- During the Attica wildfire response (2018), the HRC reported more than 800 individuals referred for psychosocial or psychiatric care, with over 65% successfully completing short-term intervention plans.
- Evaluations from the Thessaly floods (2023) showed faster identification of at-risk individuals and improved collaboration between Civil Protection and NGOs.
- The referral model has since been integrated into national emergency protocols as part of Greece’s Disaster Risk Management strategy.



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7. Lessons Learned and Success Factors

- Coordination between agencies is essential to avoid duplication and confusion.
- Digital referral tools improve efficiency but require robust data protection policies.
- Local partnerships and training enhance sustainability.
- Continuous supervision and feedback loops ensure quality of care.

8. Transferability and Adaptability

- The model can be easily adapted to other EU countries with Civil Protection systems and Red Cross/NGO networks.
- Transferable to refugee reception and public health emergencies (e.g., pandemics).
- Compatible with IASC and WHO frameworks for integrated mental health support.

9. Ethical Considerations

- Confidentiality is maintained at all stages of referral and data management.
- Informed consent is required before sharing personal information.
- Sensitive data is stored according to GDPR and national privacy laws.
- Peer supporters receive guidance on ethical boundaries and data protection.

10. References

Hellenic Red Cross. (2019). *Psychosocial Support Services after the Attica Wildfires – Evaluation Report*. Athens: HRC.

Ministry for Climate Crisis and Civil Protection. (2023). *Disaster Response Coordination Framework*. Athens: Government of Greece.

Inter-Agency Standing Committee (IASC). (2007). *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: IASC.

World Health Organization. (2019). *Mental health in emergencies*. WHO Fact Sheet.



Resource 5

1. Title of the Best Practice

Promoting Organisational Resilience and Supportive Leadership – Nordic Network for Psychosocial Support in Crisis and Disasters (NORDRESS)

2. Related Training Module

Module 6 – Post-Disaster Mental Health Support Systems

3. Context and Background

The Nordic Network for Psychosocial Support in Crisis and Disasters (NORDRESS) is a collaborative initiative launched in 2015 by universities and Civil Protection authorities in Iceland, Norway, Sweden, Finland, and Denmark.

Its aim is to strengthen psychosocial preparedness, leadership, and resilience within emergency and crisis management organisations.

NORDRESS promotes a preventive organisational culture that normalises emotional wellbeing, fosters supportive leadership, and integrates mental health into everyday operations.

4. Objectives of the Practice

- To embed psychosocial resilience and wellbeing into organisational structures.
- To train leaders to identify early signs of stress and promote open communication.
- To reduce stigma and encourage a culture of empathy, reflection, and peer support.
- To build long-term organisational capacity for crisis response and recovery.

5. Description of the Practice

The NORDRESS approach involves three interlinked components:

1. Leadership Training and Capacity Building



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Workshops for managers and supervisors on stress awareness, trauma-informed leadership, and communication.

Leaders learn to conduct “emotional check-ins” and model healthy coping behaviours.

2. Organisational Policy Integration

Each participating agency develops or updates internal policies to include mental health as a key component of safety and operational readiness.

The approach is guided by the *Nordic Psychosocial Support Framework*, aligning with WHO and EU Civil Protection principles.

3. Peer and Cross-Agency Collaboration

Regular network meetings and simulation exercises allow leaders to exchange practices, share lessons, and assess psychosocial readiness.

Online tools (developed by NORDRESS and Karolinska Institutet) provide ongoing learning materials and self-assessment resources.

6. Outcomes and Impact

- Participating organisations report improved staff morale, reduced absenteeism, and greater openness in discussing stress and mental health.
- A 2022 evaluation by the University of Iceland showed that trained leaders demonstrated stronger team cohesion and crisis communication.
- Cross-agency collaboration enhanced regional resilience and standardisation of psychosocial protocols across the Nordic countries.

7. Lessons Learned and Success Factors

- Sustained leadership engagement is crucial for cultural change.



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- Integration into policy and training, not ad hoc activities, ensures impact.
- Peer-to-peer exchange across agencies helps maintain commitment and innovation.
- Challenges include ensuring consistent implementation and overcoming resistance from traditional command cultures.

8. Transferability and Adaptability

- The model is highly transferable to other EU contexts where cross-sector collaboration exists.
- Can be adapted to national Civil Protection systems, hospitals, or large NGOs.
- Serves as a blueprint for integrating psychosocial resilience into organisational governance.

9. Ethical Considerations

- Respect for confidentiality and voluntary participation in all psychosocial activities.
- Leaders receive supervision to maintain boundaries and avoid coercion.
- Ensures gender-sensitive and inclusive leadership approaches.

10. References

NORDRESS. (2022). *Building resilient organisations: Nordic approaches to psychosocial support in crises*. University of Iceland.

Karolinska Institutet. (2021). *Leadership for psychosocial resilience in emergency response organisations*. Stockholm: KI Press.

University of Oslo. (2019). *Nordic network on psychosocial support: Evaluation report*. Oslo: UiO.

World Health Organization. (2019). *Mental health in emergencies*. WHO Fact Sheet.



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