

EMOTIONAL RESILIENCE

Lessons from the real world:
A practical guide after crises and major incidents



RESILIENCE FIRST
SURVIVE & THRIVE

In partnership with



This guide has been written by Dr Liz Royle at KRTS International Ltd in collaboration with Resilience First, and is published as part of Resilience First's portfolio of work on Emotional Resilience.

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Resilience First is a not-for-profit membership organisation which has the aim of advancing resilience in business communities and society.



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FOREWORD

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John is an Advisory Board Member of Resilience First.*

Dr Liz Royle, Director at KRTS International Ltd, has over 25 years' experience of working on crisis mental health and psychological trauma. She is thus well placed to be the lead author of this excellent paper that builds on earlier work conducted by Resilience First.

The matter could hardly be more important. Dr Royle points out that poor mental health pre-Covid-19 cost UK employers approximately £45 billion annually. Because of the pandemic, the statistics are now even worse. It is, therefore, incumbent on employers to read and adopt the recommendations that she sets out in this paper. This is not just to ensure healthy productivity and revenue. There is also a clear moral imperative to be actively interested in employees and their wellbeing – in short, to demonstrate good leadership.

With that in mind, the author explains simply and clearly what needs to be done to reduce the likelihood and impact of trauma through effective education and support. Those employers who follow her advice, getting to know their people and building trust throughout their organisations, will build healthier, happier and more productive organisations. They will find that their employees will be relatively resilient in the face of traumatic incidents and will recover more quickly. They will also understand that the more significant the traumatic event the more likely that a 'ripple effect' extends well beyond those who personally witnessed events in the first place.

Regrettably, many employers consider that there is little risk of major trauma affecting their businesses, and therefore fail to take the necessary steps to build the process and develop the thoughtfulness that will enable a range of reactions to trauma to be identified and mitigated. Yet others are emotionally illiterate and hence are unable to connect with their employees and spot the warning signs. There are more who, while acknowledging that preparing to deal with trauma is important, fail to take action. Thus, Dr Royle states that over two-thirds (69%) of managers admit that supporting employee wellbeing is a core skill but only 13% actually make the effort to access the relevant training and develop the skills and confidence. Furthermore, the training needs to be right, otherwise counselling

services not specifically focused on trauma are likely to be ineffective with employees going sick for months and many never returning to work.

The author warns against simply providing 'signposts' that indicate where employees can access help. This is because of the human tendency to deny issues or avoid them. Even where those affected by trauma do have access to professional services, Dr Royle states that 80% will delay until symptoms have drastically escalated or will not access treatment at all.

That said, there are grounds for optimism. Dr Royle suggests that younger employers are more emotionally aware than their forebears and, therefore, less likely to promote an old-fashioned 'crack-on' attitude that so clearly fails to work as a longer-term strategy. The inference is that the coming generation of leaders will be more likely to create working environments conducive to emotional and psychological resilience.

In terms of what is to be done, the author helpfully divides her advice into three stages: preparation, response, and professional services. Thus, she combines proactive and reactive measures. She reminds us about the need to be explicit about the rationale for any strategy and to ensure there is buy-in at all levels. She exhorts us to test what we put in place as a key element of business continuity scenario-based exercises. She sets out the importance of empowering staff to help themselves and each other. She also emphasises the need to follow up, thus avoiding the mistake of prematurely assuming that the job is done. Otherwise, there is a danger of mistaking resilience for recovery and thus turning a blind eye to the longer-term effects on individuals and organisations alike.

I thoroughly recommend that all employers take due note of Dr Royle's excellent paper. They will thus develop both their own and their subordinates' leadership capabilities and, by helping their employees to become more resilient, will enable better and more successful business.



INTRODUCTION

Pre-Covid, poor mental health cost UK employers around £45 billion annually and caused 5.8 days annual sickness absence per employee on average. Presenteeism cost three times more than sick leave.ⁱ

The ripple of a psychological crisis or major incident extends like a thread through the fabric of our society. The link between psychological trauma and family breakdown, drug and alcohol abuse, homelessness, violence, suicide, poor physical health and crime is well established.

It goes without saying that Covid-19 has severely tested emotional resilience on a wide scale. Mental health is perceived to be more important than ever so it is a timely opportunity to reflect on the realities. Many organisations and end users are scrutinising how they tackle this subject, requiring more efficiency and effectiveness, and fewer challenges and waste. Many suspected their strategies were missing 'something'.

To be able to address the topic following an earlier report on the subject – see 'Emotional Resilience: A guide for business when preparing for, and recovering from, major incidents' (February 2020)ⁱⁱ – Resilience First has collaborated with trauma specialists KRTS International Ltd to produce this report.

In compiling this report, information was gathered from a range of people and organisations through a series of interviews and compared with the available literature and clinical experience. Selected quotes from interviewees are cited. By bringing together a range of perspectives, this report aims to provide:

- ▶ An overview of the theory and best practice as agreed by professional bodies and clinicians around the world.
- ▶ What organisations feel are the key ingredients to successful implementation.
- ▶ The common pain points and pitfalls as experienced 'on the ground'.

The report concludes with recommendations for overcoming challenges and maximising efficacy and efficiency.



**PART 1:
CRISIS AND
TRAUMA RESILIENCE**

Resistance, Resilience and Recovery

Without doubt, there is international consensus amongst professional bodies and clinicians regarding best practice for creating emotional resilience for crises and traumatic events in the workplace.^{iii iv v vi}

The model of 'Resistance, Resilience and Recovery' sets out a continuum of measures, each area building on the others and combining for maximum efficacy.^{vii} We can illustrate this concept with the example of medical staff working in a busy emergency hospital.

Resistance is the presence of pre-existing characteristics that protect individuals and groups from the impact of potentially distressing or traumatic events. Resistance to trauma should be built from sufficient occupational training, its focus bringing a healthy detachment, team cohesion and leadership as well as having a sense of purpose and competence in managing situations that many others would find disturbing. However, there will still be times when a difficult incident in work causes distress that may take a few days or even weeks from which to bounce back.

Resilience is the ability to bounce back rapidly and even be strengthened as a group or individual. Crisis intervention is used to manage symptoms, facilitate the mind and body's adaptive processing of the event, and return to the original state.

There will be other times when an incident is emotionally overwhelming or shatters their beliefs about themselves or their world. This is the Recovery phase where trauma-informed counselling and psychotherapy are used.^{viii}

It is crucial to acknowledge that each area impacts on others and can strengthen or undermine an overall plan.

The five factors of successful crisis intervention

Irrespective of its nature, a crisis or trauma usually has shared consequences for those involved:

- ▶ Feeling unsafe long after the actual (or perceived) threat has subsided.
- ▶ A degree of chaos or great disruption to normal life along with a loss of ability to focus, make decisions and concentrate whilst the brain is working hard to process what happened.
- ▶ Feeling helpless and disempowered, with traumatic stress symptoms leaving people feeling out of control of their body and mind.
- ▶ Isolation and a sense of being 'different' to those around us – for many reasons, trauma often causes us to withdraw from our social-support networks.
- ▶ The feeling that life will never be the same again or even of being 'damaged'.

Crisis intervention is a temporary, active and supportive entry into the life situation of an individual or of a group during a critical incident or period of extreme distress.^{ix} With crisis intervention we need to be clear as to the outcome we are trying to achieve so that we do not stray into the area of psychotherapy and recovery. **If we do that, then we can actually delay or prevent recovery.**

The vast majority of people will recover with good trauma-informed education and social support. We should not use medical or pathological approaches to what is actually an adaptive and normal reaction to an abnormal event.

Effective crisis interventions should work towards reversing the negative impact by promoting these five factors: ^x



A sense of safety



Calm




A sense of self
and community
efficacy



Connectedness



Hope



**PART 2:
PLANNING AND
PREPARATION STAGES:
IMPLEMENTATION
CHALLENGES AND
SUCCESSSES**

To have a proactive and clear strategy which informs operational response means organisations can seamlessly flow into a structured reaction that is thorough and not chaotic. Where an organisation was perceived as having no or low risk of major trauma, preparation was not seen as relevant. A crisis often resulted in policies being prepared retrospectively at a massively increased cost to the organisation.

“Following the incident, we quickly realised we needed a different approach.”

Several objectives fall into the planning and preparation stages. Best practice recommends that organisations need to: xi xii xiii xiv

- ▶ assess the nature and type of risk;
- ▶ create a clear rationale for intervention;
- ▶ develop written procedures and identify responsibilities of key people;
- ▶ prepare post-incident resources;
- ▶ train staff who are (or are responsible for those who are) at risk of exposure to crises or trauma; and
- ▶ determine how to monitor and evaluate strategy.

When starting to plan ahead, several interviewees felt there was a lack of clarity around best practice and would have liked a simple “off-the-shelf” framework. There was little appetite for ISO standards and guidance with complaints ranging from: there being too many to practically do, a lack of them being “joined up”, and even some cynicism around the costs involved. Guidance was felt to focus on the “what to do” and not the “how to do it”.

A perusal of the literature on crisis interventions is equally unhelpful as it is easy to get confused or overwhelmed. There are interventions for different sizes of groups, different timings and situations, and delivered in different ways by different professionals or peers. Many similar interventions have been created with a different name often commercialised using fancy acronyms, all excellent for a game of buzzword bingo but not helpful for the continuity of business operations.

Amongst interviewees, there was a preference for learning from peers or networks in similar industries. They would often rely on Human Resources or people with some previous uniformed (Service) experience either to research options or apply systems that had worked within those settings. Although this was perceived as helpful, it can bring its own potential pitfalls. Strategies may not translate to another culture or be appropriate to the level of risk and, at worst, it could be a case of the blind leading the blind.

Creating a comprehensive approach

A best-practice approach stems from crisis-informed resources that dovetail into a comprehensive methodology for wellbeing with clear pathways and triage systems.

Common pitfalls included having a disjointed strategy with one-stop solutions. This was confusing for end users and could waste resources through duplication or overlap. A one-stop solution such as a meditation app can lose its value if the wrong people access it and feel they have not been helped when they would have benefited from a different service.

“I know we have lots of resources but it’s hard to know which one is the right one and I don’t want to waste people’s time or look stupid by going to the wrong place.”

A good example is a global technology company that uses wellness workshops, regular topical webinars and staff articles to highlight services, and explains what they are for specifically and how, when and why an employee may access aspects of the services. This also creates a culture of acceptance and awareness. A simple flowchart can help people self-triage with confidence to the right place rather than providing a generic helpline number.

In-house supporters

To create resilient workplaces, managers need the skills and confidence to recognise the range of crisis reactions, offer informal social support and signpost employees to additional support when necessary. Over two thirds (69%) of UK line managers say that supporting employee wellbeing is a core skill but only 13% have received training in this.^{xv}

For higher-risk organisations, peer supporters can be a valuable asset but must be trauma informed. Whereas peer listeners can be helpful for generic mental health, crisis and trauma support needs to avoid emotional expression. During trauma, emotions are suppressed and things happen too quickly for usual thought processes to make sense of what is happening. After the event, emotions may come out in the form of laughing, crying or anger. The individual may wish to talk or may still be numb or in disbelief.

Clinical best practice advises that we should take care with the timing of expression to avoid consolidating memories. It is recommended that there is no detailed verbal expression of emotions for at least six hours and longer if possible.

Gaining an overview of the facts is more important and can help reduce distress as people put together a short cognitive narrative. Offering a quiet space with a supportive trauma-informed helper allows the body and brain to begin to catch up with what happened. It is also an opportunity to provide empowering psychological education. An insistence on ‘talking’ may impede or inhibit normal recovery; our initial goal is to avoid people becoming overwhelmed by strong emotions.^{xvi}

Good practice involves having a clear and robust process for recruiting peer supporters, checking suitability for crisis-focused work through a series of interviews, maintaining standards and avoiding putting the peer supporter at risk of vicarious trauma.

Two separate interviewees in national logistics and cash-handling organisations reported on the challenges of supporting employees following frequent armed raids. They explained how using generic mental health first aiders caused sickness absence to skyrocket. This was because they were limited to listening, asking people about what happened and referring them to their doctor (who mostly signed them off sick). Counselling services that were not trauma focused were so ineffective that employees were off sick for an average of six months and many did not return. This led to massive costs for one of the organisations and a manpower crisis for the other that threatened business continuity.

Adapting to the culture

“Don’t pay lip service to it and drive from the top.”

Each organisation brings its own culture to the mix and it is crucial to work with this. The culture affected how receptive people were to the subject. Most interviewees felt there was a mixed bag of attitudes within different levels of the organisation itself. It was also felt that the younger generation and those in creative industries were more emotionally aware. Critically, all agreed that trust in senior leaders is essential: if not, employees are emotionally disconnected anyway.^{xvii}

There were several reports of how helpful it was for an organisation to keep the concept of resilience at a high level but caveats included the need to consider succession planning for key influencers and cross-skilling across senior leaders. It was important to acknowledge that different organisations, and different people within them, have different priorities. The rationale for properly engaging in the strategy needed buy-in from top to bottom. For example, talent retention may be a priority at one level and reducing low-level team friction at another.

The personal characteristics of employees in a culture such as personality disposition also need to be considered. For example, in a dynamic, fast-paced organisation such as retail (where managers need to be flexible and manage daily crises amongst the current stresses of supply chain and other uncertainties), managers were felt to have the mind-set and pace of life to deal with trauma better. This could mean that they were either particularly receptive to learning about their own resilience or more often did not see it as relevant.

A ‘crack-on’ attitude can hide fear or discomfort. In those cases, interventions need to emphasise their solution focus, be practical and pragmatic, and avoid a victim mentality. An appropriate level of grim humour was seen as a helpful coping strategy. There were reports of resistant attitudes based on a perception of the subject being “pink and fluffy” or part of a “snowflake” generation.

Without understanding the cultural ways of coping, an organisation can inadvertently remove them. An example was the closure of gyms across many police stations for cost-cutting purposes. Though it slashed direct costs, it increased the indirect costs to the organisation disproportionately by removing the informal social support in a safe, healthy setting and replacing it with discounted, public gym membership. This fiscally led approach did not account for the loss of a crucial coping strategy and resulting drop in resilience which increased the number of personnel who were absent or merely ‘present’ at work.



**PART 3:
RESPONSE**

When an incident occurs, our pre-planned processes should mobilise immediately.

It is widely accepted that organisations need to:

- ▶ provide a needs-based continuum of care (see Figure 1);
- ▶ provide trauma-informed psychological education to prevent escalation or suppression of symptoms and empower staff to help themselves;
- ▶ mobilise social support networks including those within the organisation; and
- ▶ triage those who need more support to clinically effective recovery services.

An immediate challenge in this phase can often be the terminology itself. The words 'crisis' and 'trauma' can be very subjective and may be better substituted for words such as a 'shock'.

"Blood doesn't have to be there for it to be trauma."

It could be difficult to identify when a response was required, particularly where there was a high frequency of events or smaller crises that were contained within a team. If organisations relied on a list of trigger events, more subtle events could be missed and, conversely, where resistance was high, resources could be wasted. Best practice indicates that support processes should work with the impact not the cause. However, it was felt that any response in of itself could validate the experience of those involved.

Figure 1:

A needs-based continuum of care for response and recovery.



Because of the complex and subjective nature of trauma, it can also be hard to identify who may be affected by an incident. Managers can be trained to recognise the impact as they usually know their teams well and can spot a variety of changes. Once an incident is identified as needing intervention, crisis communication is vital to fulfil the human need for safety and leadership.

In a world of limited resources, the assessment and prioritisation of needs mean that, as much as it is important to, we need to accept that we cannot identify all those who may be affected and exactly when this happened, so other methodologies are needed.

An employee is killed whilst carrying out their duties

With this type of event, vicarious trauma, empathic identification and reactivated trauma mean the ripple effect potentially extends across the whole organisation. Outside of those directly involved, it will be impossible to predict accurately who may need support and at what level. As part of the strategy, ongoing education sessions, assessment of need, and reminders of crisis and recovery services, mean that support is extended to those who are not ready or able to accept it immediately.

Using existing digital communication channels to distribute a psycho-education app across the work community allowed the organisation to reach 12,000 staff immediately with empowering information. A focus on 'how to help yourself and others' mobilised social support whilst encouraging those in need to self-refer. This effectively helped people triage themselves and ensured services were focused on those in need.

Trauma-informed education should include guidance on simple strategies, with advice both on which strategies were helpful in a particular scenario and those strategies which may be unhelpful. This gives informed choices and empowers people. Individuals should be provided with an overview in simple terms of common reactions across usual symptom categories. This can mean that people have greater confidence in taking appropriate responsibility for their recovery and are also more vigilant of themselves and each other and are empowered to take early action to manage reactions.

Social connections and support should be facilitated. There is overwhelming evidence that good social support is a major protective factor following trauma. We want to facilitate social connections and support, and to highlight how people can help each other. It is often helpful to give additional written information to family and friends. One common pitfall is immediately sending people home, adding to their isolation and creating negative associations of work and danger!

With some incidents, we need to take a longer view as there is the potential for new trigger events such as media reports, funerals, inquests and court cases. We should consider delayed onset reactions and the fact that organisational leaders and incident investigators will still be focused on the task and unable to consider their own needs for some time.

One size does not fit all

Sometimes we need to work with multiple people who have been affected by trauma, whether this is a whole community or groups within an organisation. Technology can be beneficial in extending reach to all and the pandemic has increased many people's familiarity with the benefits of technology. However, 80% of health apps do not meet the necessary standards for quality according to the Organisation for the Review of Care and Health Apps (ORCHA).

In a needs-based continuum of care, we should offer a range of interventions and avoid the 'counselling or nothing' scenario. Some people will find face-to-face support helpful while others prefer the privacy and independence of self-help materials, whether this is in hard or soft copy.

Crisis intervention is an important bridge to the recovery phase for those who need it. Crucially, we want to identify individuals who may need further support and to facilitate referral to recovery services. All crisis intervention requires follow up action. This may be a simple check-in or phone call to identify if they are recovering well or if a referral is needed to professional or practical support agencies. Written material should talk about further support – when, where, how and why it should be accessed.

Organisations may overly rely on professional services as a panacea whilst neglecting resistance and recovery. Of those organisations interviewed for the report, the majority were relying on counselling or therapy services as their support options.

Building engagement

“If you build it, they may not come.”

Even when an affected employee has access to professional services, as many as 80% of those with trauma will not access treatment or will delay until symptoms have drastically escalated. It is often the people that most need the help that find it hardest to access it. People commonly suppress or deny reactions as part of a natural avoidance symptom, and engagement with support services was reported by many as the biggest challenge.

It is common for an organisation to bring in crisis workers after an event and simply signpost people to them. What usually happens is the crisis worker is left sitting in a room as people find it too hard to go and speak to a stranger. Where recovery services are needed, there is still a stigma to acknowledging a problem and seeking support; it is not enough simply to signpost to the employee assistance programme.

Along with the practical barriers caused by the need for a traditional hourly session, there are many complex concerns:

- ▶ Many people who have been suppressing strong emotions fear that therapy will lift the lid and they will be catastrophically overwhelmed.
- ▶ There are many negative stereotypes of mental-health professionals – they make people cry, judge them or medicate them.
- ▶ There is also a misconception that mental-health services do not actually work so what's the point in going?

The message from clinical best practice is consistently that trauma needs a different approach to general mental wellbeing. This is particularly crucial as we move into professional mental-health services where clinical guidelines are clear that non-directive counselling is unhelpful and trauma therapy is a specialist area.^{xviii}



**WELCOME
BACK!**

**PART 4:
LESSONS FROM THE
COVID-19 PANDEMIC**

Please wear
face mask

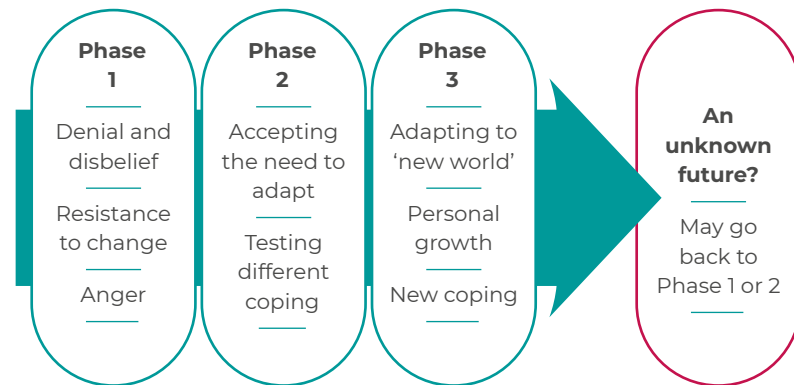
Use
hand sanitiser

Maintain
safe distance

Adapting to multiple, chronic crises

There have been vastly different experiences of living through the pandemic. Differences resulting from personal bereavement, illness, over-work, furlough or job / industry loss, socio-economic factors and personality disposition have meant we were not all in this together.^{xix} For some in administrative roles, the pandemic involved dealing with multiple death notifications of employees whilst being initially isolated from their supportive teams.^{xx}

Figure 2:
The stages of an emotional crisis.



An emotional crisis tends to follow a three-phase pattern with a beginning, a middle and an end, as shown in *Figure 2*. At first, we try to keep things as they were. We use denial and disbelief, and

struggle to maintain our routines and usual coping. We express our anger and other fear-based emotions to those around us.

In the middle stage, as we accept that we must adapt, we find it easier to look for new coping strategies. We make better choices in our self-care and reduce our consumption of things that are bad for us. We become more creative and motivated to make these choices. We re-evaluate our life and values, and many employees have done just that both personally and professionally. Major change in one area of life can make it easier to consider other major changes. A recent report claims that more than half of employees are considering leaving their job in the next 18 months.^{xxi}

Until we acknowledge the emotional impact of the crisis, this middle phase can be postponed. We all go through these crisis phases in our own time and it is important to acknowledge that some people will take longer to adjust. The danger is that people start to feel out of step with others and that they should be feeling better. The crisis is not linear and we are constantly adapting to the changes in our very personal world.

In the final phase we have adjusted and can come out of the crisis stronger. We may have learned more ways to support each other and ourselves. We are more appreciative of what we have and more tolerant of others who have gone through the experience.

This three-stage process may involve dipping back and forth between the first two phases. We may notice we are having good days and bad days but eventually the proportion of good days will consistently outweigh the bad as we move into the third phase. The pandemic has had, and continues to have, many ripples at different times. Organisations have had to anticipate the next ones, take account of different team-coping skills and needs, along with practical issues and consistent communication with people. Technology has been a major boost here and many interviewees questioned how they could have managed if this had happened before the Microsoft Teams / Zoom era.

Continued fallout from Covid-19, including further lockdowns or disruptions to day-to-day business operations, is considered by small- and medium-sized business (SMEs) in the UK to be the most critical external risk they face.^{xxii}

There will be many more changes and uncertainty ahead that can restart the process although each time we will generally adapt faster as we build our tolerance to uncertainty and trust our ability to manage the changes. Crises bring loss – in many forms and severity for different people – and these may take longer to deal with.

It is too early to assess the real impact on mental health in such a chronic, non-linear crisis but initial reports suggest a major increase in Post-Traumatic Stress Disorder (PTSD), anxiety and depression.^{xxiii xxiv} Interviewees reported sensing a real and growing fatigue. It is important to remember that adversity and how we adapt to major change can either build or break resilience.

“Will it be – I got through this – or the last straw?”

How we respond depends on how we adapt or whether we use mal-adaptive coping measures (this is an area we can influence with crisis intervention), the amount and timing of stress, and our own circumstances over time.

As humans, we need a degree of stress but we also need to ensure recovery processes are in place to avoid burnout. There is a clear imperative to recognise the needs of leaders who have been responding throughout Covid-19. Organisations need to review their needs within a very challenging time for them so as to avoid this burnout. Leaders often go into ‘mission focus’ and do not easily consider their own needs. Organisations need to watch for

tipping points and not make assumptions about their people as resilience fluctuates.

Having said that, the theory of post-traumatic growth highlights how intense adversity can actually strengthen us in many areas of life.^{xxv} Whether this post-traumatic growth benefits the organisation or leads to a loss of talent will hinge on how the organisation is perceived to demonstrate care for an employee’s physical, mental and emotional wellbeing, and alignment with their changed values.



PART 5:
RECOMMENDATIONS

In a crisis we have an opportunity to make a real difference to people's lives but if we are not careful we can do real harm. No matter how resilient we are, if the system we are in is toxic (home or work) then we will reach a limit. If recovery services are ineffective or inaccessible, the organisation is wasting resources and inadvertently increasing barriers to the right kind of care for those who need it.

All factors in the **Resistance, Resilience, Recovery** continuum are complementary when building true emotional resilience. Where an organisation does not consider resilience within this continuum, there will be weaknesses.

Preparation

- ▶ Consider the Resilience, Resistance, Recovery model to determine strengths or weaknesses in an overall plan.
- ▶ Be explicit about the rationale for any strategy and ensure there is buy in at all levels.
- ▶ Work with the culture by understanding the underlying issues for resistant attitudes.
- ▶ Be proactive in drawing up support procedures and test these as part of any business continuity / emergency planning exercises and simulations.
- ▶ Role-specific health and safety risk assessments should consider mental-health issues arising from the range of crises and psychological trauma.
- ▶ A combination of proactive and responsive control measures that can mitigate the risks for all these areas is highly recommended.
- ▶ Avoid a disjointed, confusing wellbeing strategy with one-stop solutions.
- ▶ Consider succession planning for key influencers and cross-skilling across the organisation.
- ▶ If peer supporters are used, ensure there is a robust selection, training and monitoring process.
- ▶ Review, and rewrite if necessary, processes after major incidents.

Response

- ▶ Always adhere to the principles of crisis interventions – an insistence on ‘talking’ may impede or inhibit normal recovery.
- ▶ Trauma-focused resilience building should be taught to employees identified as ‘at risk’ of encountering crises or occupational trauma.
- ▶ Managers should be aware of the signs and symptoms of traumatic stress.
- ▶ Additional guidelines for trauma-specific rehabilitation processes should be available to all involved in the process.
- ▶ Rather than drawing up a list of events that require intervention, work with the impact not the event.
- ▶ Empower staff to help themselves and each other.
- ▶ Crisis communication is vital.
- ▶ Don’t mistake resilience for recovery.
- ▶ Crisis intervention should be seen as one part of a co-ordinated trauma-support programme and never used as a stand-alone intervention.
- ▶ After an incident in the workplace, reach as many employees as possible with empowering information e.g. via digital means.
- ▶ Facilitate triage and self-referral to recovery services.
- ▶ Review the needs of leaders who have been responding throughout the Covid-19 pandemic or following any major incident.

Professional services

- ▶ Avoid offering ‘counselling or nothing’. The majority of people will need something in between.
- ▶ Proactively discuss with Human Resources or the Employee Assistance Programme (EAP) provider what they would offer following a crisis or trauma and compare this to best practice. (Note: Not all EAPs have expertise or provision.)
- ▶ External agencies should provide specific trauma-focused literature on their services that emphasise the nature and effectiveness of what is offered.
- ▶ Monitor and evaluate services.

ACKNOWLEDGEMENTS

Resilience First is grateful to Dr Liz Royle, Director at KRTS International Ltd, the lead author of this report. Dr Royle has over 25 years' experience of working with crisis mental health and psychological trauma and has helped diverse organisations such as local government, NHS Trusts, Fortune 500 companies and the Council of the European Union prepare for, and respond to, the complete spectrum of incidents.^{xxvi}

KRTS International Ltd is an award winning, digital health company specialising in psychological trauma and crisis mental health support. They bring decades of solid clinical and operational expertise to manage the human risks posed by the impact of workplace and community crises and trauma, offering innovative global e-health solutions, training and consultancy for psychological trauma and crises. KRTS is passionate about helping organisations around the world build trauma-informed emotional resilience with their underpinning model of 'Prepare, Prevent, Protect'. KRTS products and services are effective, scalable, easily implemented and based on internationally accepted best practice. Workplace crises are a global issue, and no company is immune. KRTS take time to listen carefully and understand each organisation's specific situation. This allows them to provide the right solution for the unique needs of any setting <https://krtsinternational.com/>

This report would not have been possible without the frank and open input from people across a diverse range of settings. Their willingness to talk about what worked, and importantly to reveal vulnerabilities and challenges, will undoubtedly help other organisations and the people they seek to support. We hope that the experience of being heard was helpful and extend our sincere thanks to them all.

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^{viii} Trauma-informed means that an approach is based on the knowledge and understanding of trauma and its far-reaching implications. See also https://hcsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

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^{xx} Psychological trauma can arise from incidents that are experienced directly or indirectly. In the latter case, this can be through witnessing or strongly identifying with the accounts of others' experiences. This is known as secondary or vicarious trauma.

^{xxi} <https://www.metlife.co.uk/ReMe/>

^{xxii} <https://cirmagazine.com/cir/c2021222302.php>

^{xxiii} Royal College of Psychiatrists press release: 230,000 new PTSD referrals forecast as a result of the pandemic <https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2021/12/03/230-000-new-ptsd-referrals-forecast-as-a-result-of-the-pandemic>

^{xxiv} Mental Health Foundation. (2020, October). Resilience across the UK during the coronavirus pandemic <https://www.mentalhealth.org.uk/coronavirus/resilience-across-uk-coronavirus-pandemic>

^{xxv} <https://krtsinternational.com/information-resources/about-trauma/post-traumatic-growth/>

^{xxvi} Including acts of terror, natural and man-made disasters, workplace violence, line of duty deaths, serious accidents, vicarious and cumulative trauma.

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