Developing a Psychological Health and Wellness Program for the Hiawatha Fire Department

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CERTIFICATION STATEMENT

I hereby certify that this paper constitutes my own product, that where the language of others is set forth, quotation marks so indicate, and that appropriate credit is given where I have used the language, ideas, expressions, or writings of another.

Signed:_____

Abstract

The problem was that the Hiawatha Fire Department did not have mechanism for providing psychological support and counseling to members of the fire department and their family. As a result members may not have access to psychological care to assist them in dealing with the stresses of responding to emergency incidents and the stressors of everyday life. The purpose of the applied research paper was to produce a psychological health and wellness policy for the Hiawatha Fire Department. There were four questions asked; (a) What are the basic components of a psychological and behavioral health system, (b) What education components should be delivered to fire department members, (c) What qualifications should employee assistance programs and practitioners have who provide services, and (d) What components of psychological and behavioral health programs do fire departments currently provide. A review of literature and interviews with subject matter experts led to the development of a psychological health and wellness policy. A questionnaire completed by 160 fire departments across the united states demonstrated that while many departments offer some components of a system, only a very few offer all. Recommendations included the adoption of the policy at a local level, and making efforts to increase awareness of this issue on a national level through regional fire schools.

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Appendicies

In February of 2012 members of the Hiawatha Fire Department (HFD) responded to a challenging, yet unsuccessful resuscitation involving a newborn. Several members sought support from their company officer and the fire chief in reconciling the resulting emotions. The regional critical incident stress team no longer existed, so the fire department medical director, a family practice physician, former field paramedic and volunteer firefighter, provided an optional debrief of the event to the members. The medical director was available, and while his personal experiences gave him some insight into the fire service, he had a busy schedule both in and out of practice. This was a short term one time approach. It became apparent a comprehensive, long term approach to managing the psychological health (PH) of members was needed.

The problem is the Hiawatha Fire Department does not have a mechanism for providing counseling and psychological support to members of the fire department and their families. As a result, members may not have access to psychological care to assist them in dealing with stresses of responding to emergency incidents and everyday life. For the individual firefighter this may ultimately lead to chronic mental health issues including post-traumatic stress syndrome (PTSD) or suicidal behavior. For the fire department this may lead to increase in behavior and discipline issues, unsafe actions and result in fire ground injuries and fatalities, and the loss of trained and experienced personnel.

The purpose of this applied research project is to produce a psychological health and wellness policy for the Hiawatha Fire Department. An action research method will be utilized to collect information regarding how fire departments are currently meting the psychological health needs of their members. This will include analysis of questionnaires distributed to fire departments and interviews with subject matter experts.

The research will answer the following questions.

1. What are the basic components of a psychological and behavioral health system for a fire department?
2. What educational components should be delivered to fire department members who act as peer supporters?
3. What qualifications should employee assistance programs and practitioners have who provide services to the fire department?
4. What components of a psychological and behavioral health program do fire departments currently provide?

Background and Significance

There is much evidence, both from an organizational level, and a national level, to pursue this project. Like many fire departments, HFD has made strides in physical health , but only piecemeal advances to providing for psychological health and therefore not meeting the overall of the members. HFD and other volunteer fire departments should be concerned with the affect that stress has on the retention of trained personnel. For the fire service as a whole, numerous studies have linked stress to both cardiovascular disease and poor memory function. There are several national consensus documents published that call for the establishment of a system of providing psychological health at a department level. However, there is little indication that information is being used at the department level to provide for psychological health and counseling.

The Hiawatha Fire Department (HFD) is a combination fire department in a suburban area. It is part of the contiguous metro area that includes Cedar Rapids, Marion, Hiawatha, and Robins Iowa. HFD provides fire protection services to the City of Hiawatha and to a small

portion of Monroe Township. HFD also provides advanced life support ambulance service to its own area. In addition, HFD provides advanced life support ambulance service to two small neighboring communities and their surrounding townships. This area includes a State Park with a large lake, and a Nuclear Power Plant. The approximate protected population is 10,000 people. Staffing consists of: (a) three full time Chief officers, The Fire Chief, the Deputy Chief of EMS, and the Deputy Chief of Safety and Training who all work four - ten hour days plus take call after 5 PM; (b) Three part-time firefighter-paramedics who work ten hour days between 7 AM and 5 PM during the week; and 55 volunteer firefighters with EMS certifications ranging from first responder to paramedic who provide services after 5 PM during the week and on weekends. Volunteer members also back up the paid staff during the week.

HFD responded to 939 calls for service in fiscal year ending June 30, 2011. Of that number, 745 were medicals, and there were 699 patient transports (Sweeney, personal communications). Atypically stressful, or potentially stressful events (PTE) experienced by fire department members could include loss of life of a pediatric patient, death or injury of a firefighter's friend, family, or acquaintance, homicides, violent deaths, or scenes of gore. Since each individual has their own level of resilience and tolerance, "just another call" for one individual, may be a potentially traumatic event to another. This may be particularly pertinent among volunteer firefighters with various backgrounds, experience both on and off the department, and levels of training. With that definition in mind, it would be nearly impossible to determine how many of the

During the course of the year, members have anecdotally reported stress or psychological issues to the Chief Officers that were not related to being part of the fire department. These issues included financial, anxiety, job security with regular jobs, and personal health. Several

members resigned over the course of the year, citing the stresses related to being able to maintain an active family life in addition to volunteering as the cause for the resignation.

The Hiawatha Fire Department has been progressive pursuing physical health and safety issues. In 2001, HFD received a large Assistance to Firefighters Grant. The purpose of the grant was to pursue health and fitness initiatives. The grant included funding for baseline physicals including EKG and TB testing, quantitative respiratory fit testing equipment, and fitness equipment. Since the grant HFD has been consistent in providing annual respiratory physicals. In addition they have offered flu vaccinations yearly and also have had training in the areas of exercise, nutrition, and back injury prevention presented. As a result of this initiative, many of the volunteer members participate in some type of physical fitness program. Almost all the members have ceased tobacco use. Physically, HFD is well on its way to being a healthy fire department.

In 2005, the Catholic Priest from the local parish was recruited as a chaplain for the FD. Since then he has become a familiar face around fire department activities, and has made himself available as needed. However, he has not had additional training in issues specific to fire service, other than attending a few fire training sessions with crews. Due to the nature of a volunteer fire department and his duties as the lead Priest, he has not had the opportunity to "ride along" on calls, or be around at high stress times.

The Chaplain reported that during his tenure several members had come to him for counseling (N. Manternach, personal communications, June 1, 2012). Several members of the fire department have also reported seeking out their own clergy following PTE's or in coping with other stressors, such as marriage and family issues.

At one time, a cohesive and active Critical Incident Stress Team existed in eastern Iowa. Critical Incident Stress Debriefings (CISD) was frequently conducted at the request of agencies involved. Following increased discussion on the validity of CISM and the publication of Dr. Bryan Bledsoe's articles related to critical incident stress in trade journals, (Bledsoe, 2003) the CISD team made some modifications to their program. Primarily, they discouraged mandatory or ordered participation in the CISD process. Based on feedback from HFD members, HFD continued to use the CISD concept. At some point, the membership of the CISD teams began dwindling. A call to Central Medical Emergency Dispatch, the answering point for request for the CISD team, found that only two members remained available for call.

Following-up on an off the department issue for a volunteer, the city clerk was contacted to check on the availability of the Employee Assistance Program (EAP) to volunteer members. It was determined that only the full time employees of the city had access to the EAP provided by the city (K. Downs, personal communications, April 2012).

The purpose of this applied research project is to produce a psychological health and wellness policy for the Hiawatha Fire Department. HFD's goal is to use the information gained in this project to further enhance the psychological support for its members and their families. HFD has a chaplain, EAP for full time employees, access to the department medical director for initial counseling, and several of the command staff members who were trained in Psychological First Aid. What is missing is a consistent, comprehensive approach to psychological health, and a formalized system for providing members and families with access counseling.

This topic is of particular interest to volunteer and combination fire departments. Firefighter retention and recruitment is a critical issue in the volunteer fire service (National Volunteer Fire Council and United States Fire Administration, 2007). Although "stress" was not

identified as a reason people left the fire service, many of the topics listed could be connected to stress (National Volunteer Fire Council, 2012). Those included increasing time commitment, wider response roles including EMS, abuse of service by the public, increasing call volumes, and less emphasis on the social aspect of volunteering. It may be that resigning as a volunteer firefighter is an easy way to cope with or reduce that stress. For the volunteer fire service to continue to thrive, it will need to provide mechanisms for dealing with related stress and psychological issues. The future of HFD as a combination agency may rest on the ability to help members cope with stressors.

Psychological health is related specifically to safety and physical health. Heart attacks are a leading cause of firefighter deaths in the United States (U.S. Fire Administration, 2011). A 2006 study showed that mental stress can produce cardiac ischemia in some subjects with a history of Coronary Artery Disease. This is even after a negative stress test or chemical nuclear test (Ramachandruni, et al., 2006). Another study shows that chronic stress can impair mental flexibility and attention (Cell Press, 2012). Both functions are critical to safe functioning on the fire ground.

A white paper sponsored by the National Fallen Firefighters foundation was published following a Suicide and Depression Summit held in Baltimore Maryland in July of 2011. Much attention was given regarding suicide. There is a shortage of data on suicide by both active and retired firefighters. It is difficult to gather that data for numerous reasons such as inconsistencies in mechanisms for recording and reporting both deceased employment. (Gist, Taylor, & Raak, 2011). One organization, Firefighter Behavioral Health Alliance, has begun attempting to collect data on firefighter suicide via a website, www.ffbha.com. In an interview with Fire Chief Magazine, Dill reported collecting info on 26 suicides in 2010, and 27 suicides

in 2011 (Rose, 2012). Because of the difficulties in collecting data it is likely this number is low. Yet with the idea that "Everyone Goes Home" even one loss of life is not acceptable. Suicide has impacted the HFD. Several years ago, a volunteer member had resigned from the fire department citing stress from his job as a reason. Several years later, he committed suicide. Members of the fire department, including the author, responded to that 9-1-1 call.

Three major national fire service organzations call for attention to the issue of psychological health and wellness:

NFPA 1500, Standard on Fire Department Occupational Health and Safety, Chapter 11, calls for fire departments to provide assistance and wellness programs to their families. Chapter 12 calls for the fire department physician to oversee the critical incident stress program. A12.1.2 lays out additional guidelines on how this should be done. (National Fire Protection Association (NFPA), 2007)

The Fire Service joint Labor Management Wellness-Fitness Initiative (WFI) devotes an entire chapter to behavioral health. The ultimate goal of this program developed jointly by the International Association of Firefighters, local fire departments with strong labor management relationships, and input by the International Association of Fire Chiefs, is to improve the quality of life of personnel (International Association of Fire Fighters/International Association of Fire Chiefs, (IAFF/IAFC) 2008). Although not a specific contract, agreement, or standard, the investment made by two leading fire service organizations would suggest that it receive high priority and be supported by both command and line level staff.

The National Fallen Firefighters organization has also invested efforts to this end. They have developed 16 life safety initiatives aimed toward reducing firefighter injuries and death. More importantly, their efforts go toward changing the culture of the fire service to one that is

focused on firefighter safety issues. Initiative 13 is "Firefighters and their families must have access to counseling and psychological support." (National Fallen Firefighters Foundation (NFFF), 2007)

One of the course goals of the National Fire Academy Executive Development course is to "improve executive ability to lead effectively within a dynamic and complex organization by enhancing the development of teams and application of research." (Federal Emergency Management Agency (FEMA), 2011) Providing access to psychological health and counseling helps with team performance. This project relates specifically to unit three, Exercising Leadership. A key point on adaptive leadership is that getting people to recognize and address realities because of self-desire, not because they are told to do so.

It also relates to unit five of the National Fire Academy Executive Development course relates to change management. A psychological health and wellness program must be developed and implemented in such a way that it will be accepted by the members, lest it will not be utilized. In effect, providing for the psychological health of the firefighters, and having them accept help, will be a big change from past practice on many departments.

"Leadership on the Line" by Ronald A Heifetz and Marty Linsky is a book that addressed methods leadership could help the change to occur. One method the book addressed this was to recognize this as an adaptive problem; it requires a change in attitude and behavior of individuals. The old way of "toughing it out" may not work for everyone. An example of the need to change an attitude was expressed following training on Suicide Awareness, in which one fire officer shared that many in the fire service avoid the topic of emotional health, because it is perceived as a weakness (Woodfill, 2012). Dealing with stress in itself is an adaptive problem. People avoid painful adjustments in their lives if they can postpone them or place the burden of

them on someone else. In coping with behavioral issues, people will place the burden of the issue on someone else, or rely on a "technical" fix alone. Fire Departments can provide technical solutions to these issues including employee assistance programs, peer support, and counseling. Until the firefighter learns new ways of dealing with the problem, it will continue to exist.

This is addressed in United States Fire Administration operational goal number three: "Improve the fire and emergency services capability for response to and recovery from all hazards." One of the objectives is to "advocate a culture of health, fitness, and behavior that enhances emergency responder safety and survival." This can be met by providing for the psychological health of firefighters aids in the enhancement of responder safety and survival.

Literature Review

The purpose of this applied research project is to produce a psychological health and wellness policy for the Hiawatha Fire Department. A literature review was conducted of existing fire service trade journals, scientific sources, and fire service media. By reviewing existing standards and programs, the literature review provided the foundational information on the basic components of psychological and behavioral health systems that have existed in the past. A review of the literature then identified the basic components of those programs for appropriateness. It also revealed future changes being planned for the standards.

NFPA 1500 is the Standard on Fire Department Occupational Safety and Health Program. (National Fire Protection Association (NFPA), 2007). In chapter 11 of the standard, it states that fire departments are to provide a member assistance program to members and their families. It specifically identifies substance abuse, stress and personal problems as areas of concern as these can affect work performance adversely. It also states that the program should

have services available that members and their families can be referred to in order to assist them to restore their health and work performance to previous (NFPA 2007).

NFPA 1500 states that fire departments should have written policies and procedures in place in relation to a member assistance program. The Policies should address specifically what problems are covered by the member assistance program such as substance abuse and alcoholism. The policies should also address the establishment of a record keeping system including the retention and access of records. The 1500 states specifically that the member assistance program records are not part of a personnel (NFPA 2007).

The NFPA 1500 addresses the requirements of a Wellness program in Section 11.2. It requires a department's wellness program to provide activities that identify both physical and mental health risk. Education and counseling are to be provided for preventing health issues and improving overall wellbeing. It also identifies specifically the establishment of a program on the effects of tobacco, and specifically calls for a tobacco cessation program (NFPA 2007). In the annex of chapter 11 it states that the FD does not have to pay for a wellness program, but that it can be shared with other entities. The programs should have the following components: (1) The location should ensure confidentiality; (2) there should be a review of the benefits to ensure that the plans cover alcohol, drug, and mental health programs; and (3) program staff should be familiar with medical and disability benefits. The annex also lists required qualifications for the member assistance program staff. These qualifications are managerial and administrative experience, skills in interviewing, motivating, and recognizing problems and "where appropriate, in counseling or related fields (Experience and expertise in dealing with alcohol-related problems is strongly recommended.)" (NFPA, 2007) There is no mention in chapter 11 or the annex of chapter 11 in dealing with cumulative stress.

NFPA 1500 continues with Chapter 12 addressing the fact that departments "shall establish, and the fire department physician shall oversee, a program to relieve stress generated by events that could adversely affect the wellbeing of fire department members (NFPA 2007)." This standard states that there should be criteria for the implementation of the plan, and gives examples of incidents of when the program should be available. Examples of incidents are mass casualties, large loss of life, pediatric fatalities, and death or injuries to firefighters. The program is referred to as a critical incident stress program (NFPA 2007) .

The annex of chapter 12 describes what critical incident stress is, and states that fire departments should have access to a critical incident debriefing (CID) team. The CID team should be made up of mental health care providers and other responders who have attended a two day training session. They should also come from a variety of backgrounds including volunteer and professional firefighters. The annex states that responders should have continuing education and attend monthly or quarterly meetings, depending on their activity level. The annex states that any member should be able to initiate a debriefing simply by requesting it through a supervisor. The CID should be held 1-3 hours after an incident. CID is confidential, is not a critique of the incident, and should encourage discussions about the event. Following the debriefing, responders should be counseled on signs of stress reactions and steps they can take to mitigate symptoms. "The CID team is often the first step in providing the help that is needed…" (NFPA, 2007).

The next edition of NFPA 1500 will be available in 2013 (NFPA Technical Committee on Fire Service Occupational Safety and, 2011). It was slated to be approved by the Standards Council on August 9th, 2012. A review of the Report on Comments document showed numerous

proposed changes to NFPA 1500 (NFPA Technical Committee on Fire Service Occupational Safety and, 2011). The new document has significant changes, providing additional guidance to fire departments. The title of chapter 11 is proposed to be changed from Member Assistance and Wellness to Behavioral Health and Wellness program. The proposal 2013 adds alcohol, anxiety, and depression to the list of problems the behavioral health program should address. The 2007 document calls for the member assistance program to identify and assist with issues. The 2013 proposal calls for the program to have the capability to provide crisis intervention, triage, assessment, and basic counseling. It also calls for referral to "appropriate clinical and specialty care from providers equipped to deliver evidence based treatment consistent with current best practices and standards of care." (NFPA Technical Committee on Fire Service Occupational Safety and, 2011). The proposal refers to providing psychological fitness for duty evaluations when the need arises.

The proposals for Chapter 12 include changing the name from "Critical Incident Stress Program" to "Occupational Exposure to Atypically Stressful Events". Again, the proposal has significant guideline changes. It calls for the establishment of protocols to address atypically stressful events and that participation in interventions will be voluntary. The 2013 edition of chapter 12 also adds that the capability for clinical assessment be in the departments behavioral health program. (NFPA Technical Committee on Fire Service Occupational Safety and, 2011)

Additional changes 1500 are related to the appropriateness of CID as a tool to aid in stress reduction and the prevention of stress related injuries. As emphasized by Dr. Bledsoe many documents indicate that the use of debriefings following an atypically stressful event are not helpful, but in fact may be harmful (Bledsoe, 2003). Despite this, CID is a popular tool and a more in depth review of the literature for this project was appropriate.

In Loss, Trauma and Human Resilience, Bonanno writes that over the course of a lifetime, many people are exposed to potentially traumatic events (Bonanno, 2004). He identifies the loss of loved ones or a life-threatening situation as highly disruptive events, and resilience is the ability of otherwise normal adults to maintain a relatively stable level of psychological and physical functioning. He cites numerous studies and analysis that finds that resilience is more common than believed. Resiliency is different from recovery. Recovery means that a person returns to normal functioning. Resilience is the ability of adults who are exposed to stressful events to maintain stability. Studies found that resilience was common among a vast majority of people exposed to stressful events, and in fact that ability to sustain normal functioning in the face of loss or trauma is not pathological, as once believed. Bonanno identifies several pathways to resilience, identifying numerous coping mechanisms. Those mechanisms included hardiness, self-enhancement, repressive coping, and positive emotion and laughter. In summary, a majority of people can recover from stressful events using their own mechanisms (Bonanno, 2004).

Recent studies funded by NIMH and FEMA looked at 142 trauma-exposed firefighters (Daly, et al., 2012). It found low rates of diagnosis for PTSD, and low symptom rates for alcohol-abuse, anxiety, and depression among professional firefighters. The rates of diagnosis or symptoms were independent of the exposure to traumatic events. What did predict symptoms was perceived social support, workplace stress, coping, and self-blame to the extent that firefighters with the highest levels of significant symptoms reported low-perceived social support and high self-blame. The authors of the study hypothesize that one reason for the low rates of clinically significant symptoms was the high level of cohesion, which is associated with

availability of social support. One future research study suggested was a broad assessment of department cohesion and community support (p. 12).

A meta-analysis published in The Lancet showed that CISD had no effect in reducing symptoms of PTSD (Emmelkamp, van Emmerik, Hulsbosch, & Kamphuis, 2002). The analysis suggested the opposite, that CISD debriefing had a detrimental effect. Among the explanations offered for this lack of efficacy included speculation that CISD might interfere with the natural processing of the event, including bypassing social support in lieu of the CISD. The awareness of normal manifestations of distress after an event is probably increased by CISD, and as a result emphasis that professional care is needed may be an unintended result. The work points out that the decision to provide CISD would not be based on empirical research, but that there was a perception of helpfulness by participants in several studies, which may justify or explain the continued use of CISD. A Cochrane review published in 2009 was the review of single session psychological debriefings that occurred since 1997 (Rose, Bisson, Churchill, & Wessely, 2002). The review showed that single debriefing sessions did not reduce the psychological distress or onset of PTSD as compared to control group. They saw a increased risk of PTSD in persons receiving debriefing, and no reduction in PTSD severity. According to this review "Compulsory debriefing of victims of trauma should cease (p. 2)."

The World Health Organization also issued a brief communication regarding the use of single-session psychological debriefing (World Health Organization, 2005). It clearly states that the use of single-session psychological debriefing for the general public, following emergencies, is not advised.

The next document reviewed was the Fire Service Joint Labor Management Wellness-Fitness Initiative (WFI) (International Association of Fire Fighters/International Association of

Fire Chiefs, 2008). In this document Chapter 5 sub title reads "Management and Labor shall support the provision of a behavioral health plan, which may be delivered either through internal or external sources, based on specific elements." This document is more extensive that NFPA 1500 with more detail as to what should be provided and how. It states that investing in the firefighter is an investment in the capability to provide a high quality level of service; mentally and physically sound firefighters are the building block of the fire service. The balancing both physical and behavioral health is key to an overall fitness program. This document states that the traditional focus has been on physical fitness component of firefighter health and wellbeing, but that has changed in a post 9/11 and Katrina world.

In chapter 2 of the WFI, a mental status exam that evaluates judgment, orientation, and short and long term memory is included in the neurological exam portion of the physical exam. If indicated, referral for psychiatric or psychological evaluation is called for (p. 13). Chapter 5 also states that a behavioral health evaluation should be conducted annually for uniformed personnel. An evaluation tool with questions regarding stress, financial and family problems, alcohol and tobacco use, substance abuse, and many other issues should be reviewed by the department's behavioral health specialist. The behavioral health specialist can meet with participating members to review the survey and offer counseling and develop a course of action to best address the issue (p. 41).

Chapter 5 discusses the qualifications of a behavioral health specialist, calling for the FD to have a behavioral health specialist who oversees the behavioral health program. The ideal candidate is identified as a licensed mental health professional with a Ph.D. or Master's in a relevant field. Specifically it states that "… it is essential that the behavioral health specialist is familiar with the unique stressors and psychosocial elements of uniformed personnel in order to

address the needs of the individual who is seeking or needing assistance" (p.40) A long list of essential training for the behavioral health specialist is listed, which includes Critical Incident Stress Management, crisis intervention, general stress, PTSD, along with familiarity of the environment of fire service personnel. Besides being responsible for providing counseling, the behavioral health specialist is also responsible for referring and coordinating arrangements for care from other behavioral health services, such as outpatient counseling, substance abuse treatment, and critical incident stress management among others on a long list of issues.

Chapter 5 also discusses that fire departments may choose to have chaplains. The chaplain can assist firefighters and their families in times of need, by assisting with spiritual needs and acting as a liaison to their own minister in addressing job issues. They also may comfort the bereaved and aid victims' families. They may also assist with death notifications, and line of duty injuries. Chaplains should use a non-denominational approach and have the ability to recognize signs of stress and take the appropriate actions. Their training should include current CISM methods.

WFI identifies a number of counseling services that should be available to personnel including but not limited to: financial counseling, retirement planning, marriage and family health, communications skills, and behavioral modification. The emphasis is on helping firefighters have a healthy balanced life and having the tools available to cope with the stresses of everyday life and the job. According to the WFI, all these identified issues should be addressed via comprehensive counseling services. Supervisors should receive instruction in making referrals and aiding their crew members in accessing these behavioral health services (pp. 41-42).

The WFI also address the need for access to an Employee Assistance Program or Labor/Employee Assistance Program (L/EAP). Access to the L/EAP can occur through a variety of circumstances: employee request/ supervisor recommendation or suggestion; adverse job performance; or participation as a condition of employment. Although the training and experience of the department's behavioral health specialist can aid an employee in accessing the right service, access to the L/EAP should be available without going through the behavioral health specialist. WFI recommends that when an employee needs referred to a licensed mental health professional; the mental health professional should have training in issues relevant to uniformed personnel, specifically traumatic stress (p. 43).

If departments do not have an L/EAP, WFI suggest that certain program elements can be provided to employees through specialized services. Substance abuse, including alcohol and drug abuse, can not only affect the employee, but can also affect the family and co-workers. Employees should know that there is support and help available to them. The WFI does point out that drug testing is not included within the context of the WFI. Although departments may have a "for cause" or new hire drug testing policies, the WFI states that drug testing is "separate and apart from this Initiative and in no instance should drug testing be part of the annual medical examination and it's blood and urine test.(p.44)" It further states that substance abuse programs should emphasize treatment and rehabilitation, rather than termination. "Rehabilitation of the individual is the most effective and compassionate means of retaining a valuable member of the department." (p.44). The WFI also includes a tobacco cessation policy and extensive information on the risk of smoking both in terms of the individual health risk and the risk to public safety as a result of smoking related fires. Smoking is an addiction and one of the most challenging

behaviors to overcome, once a regular user. Tobacco use and cessation assistance should be part of a behavioral health program (p. 45).

The WFI calls for an effective stress management program as part of a behavioral health program, and prevention is the most logical means of managing stress. Stressors can occur as part of the job, firefighters have the front line exposure to many stressors, but the rigors of a firefighter's life can also cause stress. Long hours, overtime, periods of high intensity and strong emotional exposure can add to stress. The stresses of fire service can take a toll upon marriages and families. For agencies whose members have routine contact with high risk patients including exposure to blood borne and airborne pathogens can add to the mental stress created by the job. The stress management program should start at the beginning of the career. New recruits should be trained to recognize reactions to stress. Experienced firefighters should visit with recruits, giving them realistic expectations of the type of stressors that can occur throughout their careers. Exercise should be emphasized as a tool to aid in reducing stress. Stress management techniques should be reviewed at promotional test taking time and during initial paramedic training. Personnel should be provided with stress assessment tools so that they can identify stress and seek support when needed (pp. 45-46)

WFI also states that departments to have a toolbox of options to utilize in providing critical incident stress management (CISM). There are many options for CISM interventions: (a) pre-incident education; (b) on-scene support; (c) large group, small group and individual interventions; (d) pastoral crisis intervention; (e) family support services; (f) and staff consultation. Mechanisms for managing post-traumatic stress syndrome (PTSD) should be included in the behavioral health program (p.47).

Chapter 5 of the WFI closes with this quote; “Fire departments must measure the investment in a comprehensive behavioral health component in more than its financial cost. Personnel suffering emotional or behavioral problems may negatively impact the overall effectiveness of a department. (p. 48).” Behavioral health issues may manifest as behavior or discipline problems such as absenteeism, safety risk, and poor customer service. Providing firefighter’s tools they need to be mentally and physically fit will allow fire departments to provide quality service to the public

In 2008, The National Association of Emergency Medical Services commissioned a paper titled “Occupational and Organizational Issues in Emergency Medical Services Behavioral Health” (Gist & Taylor, 2008). While NFPA 1500 and the WFI are written more as fire service documents, this document focuses more on emergency medical services. Much of the work load of HFD and other fire departments today are medical calls. The EMS personnel are active participants in many of life’s stressful events and the very nature of the work puts EMS staff in contact with demanding and difficult customers. The authors call for systems to have elements in place prior to any precipitating event, rather than relying on responses after the event to deal with stress. Similar to NFPA 1500 and WFI, the authors write about an entire system, including organizational factors of management, command, and supervision that aid the EMS workers in coping with stress. How an organization handles a significant event is demonstrated by how they handle everyday operations. Gist and Taylor address this in a three tier approach

The first tier addresses management. In their document, management refers to how an organization functions day to day. The hygienic factors of a workplace will have an effect on employee satisfaction. Employees who are already unhappy with how their work impacts their life may blame the department after a stressful event. Issues like pay and benefits, schedules,

decision making and communication will also effect employee satisfaction, Employees who feel like a part of their organization are more likely to move forward and focus on how they handled an event, and how to do better next time. The authors of the paper encourage leaders to build an organization with strong provider commitment and involvement (Gist & Taylor, 2008).

The article further addresses in the second tier in that while management is how an organization runs day to day, command refers to how the organization handles emergencies. The authors point out how an organization that moves from the inclusiveness of management to a hierarchy of incident command and back to everyday functioning can have an effect on its resiliency and organizational ability to handle stressful events. "If you want to control incident stress, you must begin by controlling stressful incidents (Gist & Taylor, 2008)." The authors also note that organizations should use the concept of after-action review consistently and routinely, as is done with incident command, to provide a mechanism for processing events and learning from them.

According to Gist and Taylor, the third tier in the system is supervision. It is often the weakest link. This is attributed to the lack of training and preparation provided for front line EMS supervisors. Supervisors function at the front line of service delivery and therefore have the most impact on many elements of service. This includes dealing with stressful events. Supervisors are also in the best position to observe the behavioral health of front line employees.

The authors identified four recommendations for behavioral health. These are particular to stress management. These recommendations are psychological first aid, the use of a nonintrusive assessment mechanism, stepped care and treatment of clinical conditions.

The first recommendation is that immediate assistance should utilize the principles of psychological first aid (Brymer, et al., 2006) . It should be nonintrusive and proximal. Initial

contacts should be made by peers with past experiences is similar circumstances. Less formal "-more in tune with what you learned from grandma than what you studied in grad school (p.320)." These visits should be more supportive and less interventional, yet allowing the individual the opportunity to seek out assistance if needed. They recommend this approach over the use of a critical incident stress debriefing.

The use of a non-intrusive assessment mechanism that is early and reliable is the second recommendation. The authors state that, in the early stages after an event, the best approach is watchful waiting and compassion. Most responders will experience some distress after a stressful event; however the greatest majority will not see that rise to the level needing clinical treatment. If a responder exhibits difficulties, then referral to a behavioral health specialist may be needed. They recommend the use of the Trauma Screening Questionnaire (TSQ). The TSQ consist of 10 simple "yes" or "no" questions where a threshold of six or more yes replies can indicate the need for further assessment for treatment for PTSD (Brewin, et al., 2002). It can be used in primary care settings, work place screening, and as a self-assessment tool.

The third recommendation is stepped care. This is providing care at a level that matches their clinical need. Basic palliative support following a stressful event is appreciated by most, but it can also be detrimental to a few. The authors cite multiple studies where this can be detrimental. Many emergency workers have developed their own methods of dealing with the discomfort of stressful occupational events and have built the skills that prevent stress from interfering with their lives or careers. When the symptoms become troublesome, EAP providers should be available to assist. Then, if needed, referral to specialty providers may be called for. Treatment and care should be provided at the level needed by the emergency worker, and not all workers handle stress the same (p.322).

The fourth and final recommendation is that treatment of clinical conditions should be by competent specialty providers who are credentialed and use evidence-based treatment. The authors point out that we expect an orthopedic surgeon to address orthopedic injuries. The authors caution that it is important for an agency to verify that a clinician is truly competent. "Documented training and supervised experience in critical techniques such as cognitive behavior therapy should be considered imperative (p. 323)."

The authors have created a flow chart for dealing with potentially traumatic events (PTEs) based on the previous elements. (See figure- NFFF). The process continues through five points, and starts with the experience of a PTE. As reviewed above, different responders will handle the trauma of an event differently, based on a number of factors. It is at this point that an expression of concern may be all that is needed. If the responder considers the event significant, they can request help.

The second point, is the holding of a hot wash or after action review, with questions such as: What happened? What was successful? What could have gone better? How might we improve? Who should we tell about what we learned? Psychological First Aid (Brymer, et al., 2006) principals can aid this process. This may be sufficient; if serious issues are present, then referral is necessary. If time passes and some issues appear to be present, a screening instrument such as the TSQ can be used to evaluate in three to four weeks post event (p.325).

The third point is the TSQ screening. Even if a responder does not meet the six yes answer threshold, if they are still experiencing some issues they can be referred to an EAP for basic assistance. The fourth point is for those members who have six or more positive responses should be referred for further assessment. A complete assessment, conducted by a qualified EAP provider should be conducted. It is possible that the EAP can help with symptom management,

or with external stressors that are exacerbating the situation. Referral for clinical treatment by a competent specialist may be indicated, which leads to the fifth point in the flow chart, treatment by a specialty clinician. The authors indicate this should be a board-certified psychiatrist, a doctoral-level licensed psychologist, or a certified clinical social worker. Any provider used must have advanced training and experience in evidenced based treatment models.

The final fundament discussed in the paper is an organizational support of a comprehensive wellness and fitness program, similar to NFPA1500 and the WFI. They discuss that the individuals own commitment to health, fitness, and wellbeing can contribute to resiliency. The agency should also make its own commitment by providing the comprehensive wellness initiative. This includes an EAP which is easy to use and is confidential. It identifies substance abuse, legal, financial, and marital and family problems as issues that a EAP should be able to address. A true behavioral health program must be part of a "comprehensive health, wellness, and fitness program that includes an effective EAP" (p. 326).

In Combat and Operational Health (specifically chapter seven), Dr. William P. Nash provides information on the Marine Corps and Navy's operational stress continuum and gives guidance to unit leaders in dealing with individuals dealing with stress (Nash, 2011). The author starts off the chapter by identifying the role of the Marine Corp and Navy commanders in behavioral health. The commanders of combat commands have overall responsibility. The operational commanders are in a position to balance and control stressors, and line commanders can lead the full range of health protection issues to "promote, protect, improve, conserve, and restore the mental and physical well-being of service members across the range of military activities and operations" (p. 108). Nash writes that only trusted leaders and mentors can reduce the stigma associated with acknowledging mental health problems. He emphasizes that although

medical and religious support staffs are essential in the care of unit members, commanders cannot delegate responsibilities for behavioral health to medical or religious support staff (p. 108). Until recently, military leaders have viewed the issue of behavioral health and combat and operational stress separately from physical health protection. Reactions to stress have been viewed as temporary and reversible responses to stress, not as illnesses or injuries. Service members with stress reactions were not allowed to see themselves as sick, ill, or injured. In Dr. Nash's opinion, scientific thought provides a strong argument that the same preventative measures taken for medical and physical health can guide models that provide for psychological and behavioral health. Recently, Marine Corps and Navy commanders have worked with mental health and religious ministry professionals to develop new tools to be used to provide psychological health protection. The resources have been developed to fit the needs of commanders at all levels. The most basic tool is referred to as the operational stress continuum doctrinal model. The continuum model recognizes the entire spectrum of responses to stress and the outcomes. It uses a four color system, Green stands for full readiness with normal functioning and coping. It progresses through to the yellow reacting zone, orange injured zone, and red ill zone. These colors can apply to individuals, families, and units.

Green does not represent the absence of stress, but rather that stress is being appropriately handled. It represent effective coping without significant distress. It features behaviors such as being calm and steady, in control, getting the job done and getting enough sleep. The goal of all military training and leadership is to maintain green zone readiness.

In the yellow zone, members are reacting. Mild and transient distress or loss of some function is present, demonstrated by being anxious, irritable, or angry. It can also be indicated by cutting corners, poor sleep and mental focus and social isolation or hyperactivity. The times

for greatest risk for entering the yellow zone are just before, and just after a challenge. Yellow zone reacting is by nature, always temporary and reversible, and concludes by returning to the green zone. Yellow zone behaviors that do not mitigate move into the orange zone (p.110).

The author describes entry into the orange zone like a tree branch in the wind. In the yellow zone, the branch bends and sways under the stress of the storm. Following the storm, the branch returns to normal. In the orange zone, the branch breaks because it's bent beyond its limit. Four possible causes of combat and operational stress are identified; a life threat provoking helplessness, terror, or horror; Wear and tear from the accumulation of stress from all causes; Loss and separation from people, objects or even a portion of oneself; And inner conflict by carrying out or witnessing acts of omission or other acts that violate ones deeply held beliefs and morals. Experiences, behaviors, and feelings may include not being able to sleep, loss of control, panic or rage, apathy, and shame or guilt. Dr. Nash writes that similar to physical injuries, stress injuries can't be undone and may leave behind a scar, but they can heal over time. In the orange zone, stress injuries are not classified as mental disorders, they don't necessarily require the training of a mental health expert in recognizing them, but commanders may rely on chaplains and medical staff to take care of these injuries (p. 111).

Red zone illnesses are mental disorders diagnosed by clinicians. However, others should be able to recognize the characteristic symptoms of stress illnesses, of which PSTD is the most widely recognized. Other common red zone illnesses include depressive and anxiety disorders, along with substance abuse or dependence. The defining characteristic for transition from orange to red zone is that symptoms persist for more than 60 days post deployment. The 60 day threshold is arbitrary, but the author believes that it is a compromise between getting timely treatment and avoiding rushing to label problems that will resolve on their own. Dr. Nash closes

the discussion emphasizing that leaders should not be concerned with whether or not an individual has a diagnosable mental disorder, but rather if the individual needs referral to a mental health professional for further evaluation or fit for duty exam (p. 112).

The author comments that no one group is able to manage the entire stress continuum. The green and yellow zones are best managed by line leadership in activities that promote resiliency. Resiliency aids the individual in recovering and prevents issues from progressing from yellow to orange. On the orange and red zone sides, issues are better handled by medical and mental health professionals (p. 112).

Five core leader functions to promote psychological health have been identified by the Marine Corps and Navy. They are strengthening, mitigating, identifying, treating, and reintegrating. Strengthening includes training, unit cohesion, and leadership. Training involves building resiliency in individuals, families, and units. Leaders can do much to strengthen members by providing realistic training that develops strength both physically and mentally. Training prepares units and individuals to handle the situations they face. Stress experienced in training also inoculates individuals against future stress in real life situations. The challenge to any leader is to develop training that is tough and realistic enough to build resilience, yet not push the individual too far. Unit cohesion can strengthen members. Developing trust not only among individual unit members but also between families and the unit by using good vertical and horizontal communications techniques can have a positive effect on unit cohesion. Having unit leaders who inspire and teach while providing good leadership strengthens the unit. Unit leaders who are functioning in the yellow, orange, or red zones themselves must manage their own stress, least they become a detriment to their unit (p. 113).

Mitigation is aimed at keeping unit members in the green zone or helping them return there after being in the yellow zone. It presents the challenge of balancing the needs for training and strengthening the unit to complete the assigned missions, while at the same time mitigating or eliminating stressors that are not essential to the mission. Tactics listed include ensuring adequate sleep and adequate physical fitness and recreation time. Encouraging participation in religious activities and enforcing ethical standards, and rotating units through assignments and for rest can have a mitigating affect. Limiting the exposure of individuals to scenes of gore, where possible and using after-action reviews are also mentioned (p. 114).

The next area is identifying. Leaders are responsible to identify stress reactions, injuries, and illnesses. An effective leader will know the individuals in their units and their specific strengths and weaknesses. This awareness should extend not just to their unit activities but to their home activities also. The leader needs to be able to identify which zone each unit member is in at any given moment. Although individuals are responsible for their own psychological health, an attentive aware leader and peers are the most effective resource in monitoring the psychological health of unit members. Leaders and peers need to watch out for each other, and this includes the psychological health of peers and subordinates (p. 114). The Marine Corps and Navy have also developed a stress decision flow chart that is made up of three questions. The first question asks there are signs of distress or loss of function. If no, the member is in the green zone. If yes, then the next question determine is if the distress or loss of function severe? If the distress is not severe, the individual is in the yellow zone with the expectation they will return to the green zone. If the distress is severe, then the final question asks is if the distress has persisted more than 60 days. That is enough time that a clinical diagnosis is possible. In either case, orange or red, the individual will benefit from the care of a mental health clinician, and should be

closely monitored. The chart can help commanders monitor their unit members and identify zones quickly (p. 115).

The treatment of stress injuries is similar to physical injury, starting with buddy or self-care, progressing through supportive care, and culminating with definitive psychological or medical care. The hierarchy of self or buddy stress care is built on the same hierarchy as self or buddy physical care: (a) sustain life; (b) minimize further damage; (c) decide if further care is needed. The Navy, Marine Corps, Defense Centers for Excellence for Psychological Health and Traumatic Brain Injury, and The Veterans Affairs National Center for PTSD developed combat and operational stress first aid (COFSA) (p. 116). It is based on the principals of psychological first aid developed by the National Child Traumatic Stress Network and the National Center for PTSD. Seven core components are identified as the seven c's (p. 116).

1. Check and assess continually for stress.
2. Coordinate with those who need to know, including leaders and family, regarding stress problems and further care as indicated.
3. Cover those who are experiencing acute distress and ensure their safety and the safety of others.
4. Calm the intensity of the physiological arousal by practicing deep relaxation techniques.
5. Connect the individual with peer support, other unit members and or family unit to restore cohesion.
6. Competence; mentor the individual back to competence in all areas of life, both occupational and social.
7. Confidence; help them restore their confidence and regain their self-esteem.

It is essential that commanders ensure the availability and provision of evidenced based care, when needed, to individual unit members. The earlier an injured or ill individual receives definitive care, the more likely they are to recover fully.

The final core responsibility identified is to reintegrate stress casualties. The challenge faced by commanders is to monitor the progress of members and mentoring them back to full duty where possible. For this to be possible, the stigma of mental illness must be continually addressed. If return to duty isn't possible, commanders are still responsible for assisting members in transition to VA care and civilian life (p. 117).

Dr. Nash notes that some of the information contained in the stress continuum model and core leader functions has not been empirically tested. They are based on scientific evidence and the approach does lend itself to further empirical assessment that other models of operational stress, based on a "less medical view of adverse stress outcomes"(p. 117).

A document on the development of an international consensus on peer support was issued in 2011 (Australian Centre for Posttraumatic Mental Health, 2007). Ninety-two experts were involved in the study. Eight key recommendations are covered in the document. A key consensus point is that all high-risk industries should have a peer support program that is well planned, integrated, and tailored to their employees. The goals of peer support programs should provide an empathetic listening ear, low level psychological intervention, identify peers who are at risk, and facilitate pathways into professional assistance. Individuals who are selected for peer supporters should be a member of the target population with considerable experience in that field that is respected by their peers. Peer supporters should be trained in skills such as listening skills, psychological first aid, and information on how to make referrals. Training standards

should be established and upheld. The clinical director for a peer support program should be a mental health professional, and involved in the training and supervision of the peer supporters.

Peer supporters should be part of routine health and welfare activities, along with being available for high-risk incidents. They shouldn't see their peers as clients, but rather, seek specialist advice and offer referrals for ongoing cases. Peer supporters should be able to maintain confidentiality except where seeking help from the clinical director or where there is a risk of harm. Employees should be able to select a peer supporter on their own from a pool of accredited supporters, and supporters should also be offered following high-risk incidents. The peer supporters should exercise self-care. Management should ensure they are not taken advantage of or on call 24 hours a day, and can access care as needed for themselves.

Clear goals should be established for the peer support program, prior to commencement of the activities. An evaluation by an independent external evaluator should be conducted on a regular basis, and both qualitative and quantitative feedback should be collected from users and peer supporters.

Psychological first aid (PFA) is a modular approach to help individuals in the aftermath of disaster (Brymer, et al., 2006). It is a supportive intervention designed to be used immediately after a potentially traumatic event. It is designed to reduce the distress caused by traumatic events and assist in adaptive functioning and coping. PFA strategies are applicable to first responders and other disaster workers and applicable across range of population, from children to elderly, exposed to potentially traumatic events. It is based on understanding that different individuals will react differently to a broad range of events. Delivery of PFA can be by a wide range of response workers, including but not limited to mental health response workers. There are eight core actions identified that PFA providers take to aid survivors of traumatic events.

1. Make contact and engagement with survivor.
2. Ensure their immediate safety and comfort.
3. Stabilize them by calming and emotionally orienting them.
4. Identify their immediate needs and concerns by gathering information.
5. Offer practical assistance in meeting immediate needs and concerns.
6. Build connections with social support networks by aiding in making contacts with family or other sources of support.
7. Provide information about stress and coping, to reduce distress and aid in coping.
8. Link survivors with available services needed either in the future or immediately.

These core actions provide the basic objectives in providing assistance immediately following an event. Providers should be flexible and base their support on the needs of the individual they are assisting. There is course available to first responders and other disaster workers or those interested in mental health.

All the sources reviewed had some commonalities that led to the development of questions for interviews with subject matter experts and the questionnaires sent to fire departments. Background information for the development of the psychological support and wellbeing policy was also gained. Prominent was that many factors outside specifics of psychological care are important. The hygienic factors of the work place such as pay and morale can affect employee attitude, therefore potentially affecting their ability to cope with stress. Training, fitness and preparation were also paramount to managing stress, as was the use of incident command and after action reports or a hot wash. The plan specifics should include, according to the literature, basic peer support mechanisms, employee (member) assistance programs, and trained counselors, and oversight. Care should be used that the appropriate care is

provided at the appropriate level, by the appropriately trained staff. Similar to medical care, the care should address the injury. While a minor laceration on the forehead does not necessarily require a neurosurgeon, it may require cleaning and dressing.

Those concepts led to some questions that were discussed during my interviews with subject matter experts (SMEs). I asked questions concerning what types of training that should be provided to both members and counselors, what are other components of the psychological health program, and what qualifications should we look for in a mental health professional.

As I completed the literature search, I had difficulty finding an example of a fire department psychological or mental health policy. The ones I found were buried deep in another wellness policy and consisted of a few lines concerning EAPs, tobacco use, etc. I didn't feel those were worthy of full review. This led me to wonder how many fire departments are actually providing a psychological health program such as laid out by NFPA 1500 or the wellness and fitness initiative. Those questions led to the basis of my questionnaire sent to fire departments. It also led me to ask "how are we doing as the fire service" of the three SMEs.

Finally, as I took into consideration the literature review, a written policy needs to be comprehensive, yet non-specific enough to allow for task and tactical changes to be made in the way the program is handled, as the science changed. NFPA1500 (2007) still calls for CISD although there is not clear science that it is the best practice. The literature review was essential in the development of my interview questions and my questionnaires for fire departments.

Procedures

Two methods were used to further explore the research questions. In regards to the first three questions: (a) What are the basic components of a psychological and behavioral health program, (b) What educational components should be delivered to fire department members who

act as peer supporters, and (c) What qualifications should employee assistance programs and practitioners have who provide services to the fire department, three subject matter experts were interviewed via telephone, using open ended questions. For the fourth question, what components of a psychological and behavior health program do fire departments currently provide, a questionnaire was used to query other fire departments. Following the collection of all information, the psychological health and wellness program policy was created.

Three subject matter experts were chosen. They were chosen for their familiarity with the fire service, psychological health, and counseling. The purpose of the open ended interview was to glean additional information not discovered in the literature search. Lisa LaDue is a licensed clinical social worker with experience in disaster response, a volunteer firefighter, and direct experience working with the Hiawatha Fire Department as a CISD provider. Jeff Dill is also a licensed social worker, career firefighter, speaker, and author. The third is subject matter expert, Dr. Richard Gist, is a published author, researcher, and speaker, active at the national level with implementing Life Safety Initiative 13. (See Appendices A, B, and C for brief biographies and edited transcripts of the telephone interviews.)

All three were contacted via email and asked to participate as a subject matter expert. They were told ahead of time and during the interview what the topic of the research was. In each case I contacted the interviewee at a number they provided. After a brief conversation, and requesting permission to record, the interviews were recorded. The interviews were transcribed by a dispatcher from the Linn County Sherriff's Office, Amanda Bieber, who graciously volunteered to assist. The transcripts were then edited by me for brevity, removal of personal information, or information that may be of a sensitive nature.

The information gleaned from the interviews was useful. The SME's provided much insight into the topics discussed. The limitation was that in an effort to keep the interview open ended, it at times wondered. When that happened, questions were asked to bring the discussion back on topic. The second limitation was that two of the individuals, Dill and Gist, were authors of material in the literature review. Some of the information was new, but some of it was also repeated from the literature review. The strength in that was that SME's had the ability to expound on some items, which provided me with additional insight not obtained during the literature review.

Survey Monkey was used to create a brief questionnaire to evaluate if fire departments were delivering the psychological health program components indicated in literature review and SME interviews. The survey consisted of 17 questions. The final two questions were optional, relating to name and comments. The questionnaire is attached in Appendix D. The questionnaire was sent out via email to two groups; (a) The Iowa Professional Fire Chief's Association (IAPFC). This email list includes 56 paid career fire chiefs. The second group emailed was the 23 cohorts from my December 2011 Executive Development class. A link to the questionnaire was also posted on the International Association of Fire Chief's (IAFC) open forum website. The web site indicated 11,291 individuals were members of that forum. The questionnaire became available on July 5th, 2012 and the last responses were posted on July 16th.

Several limitations were noted. First, there was no way to track the total population who actually received the questionnaire. The second limitation was that the recipients who are active in the IAPFC, IAFC forum, and enrolled in the EFO program are going to be more attentive to national fire service issues by nature, and thus the answers may give the impression that more fire departments are providing those program components than actually are. Another limitation

was relying on the knowledge of the individual completing the questionnaire. For example, the questions regarding the availability of EAP services to families and part time and volunteer members. I personally did not know that answer and had to ask the City Clerk, who then queried the insurance provider who actually provides the EAP service as a benefit. It's possible that rather than research the question they simply answered it to the best of their ability. As with any questionnaire or survey posted on a forum, there is a chance that multiple individuals from same agency may complete the survey. Regardless of these limitations, the questionnaire painted a fair picture of what fire departments across the United States are doing regarding psychological health.

This may be the point to discuss why question four was asked, and what the significance of the information collected is. The future of this project will be to present it to city council for approval and funding. (See recommendations section). In my experience, one of the first questions that council members will ask is "What are other fire departments doing?" Having the answer to this question will aid us in obtaining acceptance of the program and funding.

Results

During the telephone interview, the following items were identified and components of a behavioral health program. Dill identified an EAP, chaplaincy program, local counselor, and provisions for transition to retirement life. LaDue expressed organizational factors including individuals being able to recognize their limitations, making mistakes without getting "their head torn off", leadership being approachable and setting a good example, and a feeling of safety both in terms of being able to approach leadership and the technical safety aspects of safe equipment and gear. LaDue felt that EAPs had some limitations in what they could do, but expressed that

having a counselor on contract was important. Gist identified the consistent use of after action reviews and ICS, in addition to information gained in the literature review.

For the educational components for fire department members, Dill stressed communications skills including how to talk and listen. Peers should be able to ask straight forward questions, and recognize signs and symptoms of distress. LaDue discussed stressing prevention methods; how to stabilize oneself during a stressful event. She also recommended the psychological first aid course. Gist recommended training on after action reviews, and discussed a new course, called Curbside Manner, that is being rolled out as a form of psychological first aid.

In regard to qualifications, both Dill and LaDue stressed having someone with experience in dealing with stress, critical incident management, and specifically working with responders. Dill suggested getting those people in and having them do ride time to become familiar with the fire service. Gist stated that an online program was being developed that could provide training to EAPs and counselors. They could learn evidenced based techniques and best practices for dealing with PTSD, anxiety, depression, and how to use it with fire and EMS people.

All three were also asked questions about the state of psychological care in the fire service. When Dill joined the fire service in 1989, physical fitness was just becoming an issue. He believes we are in the early stages of understanding psychological health. LaDue said that the CISD and CISM movement was a good thing; it brought attention to the issue, however, the demise of that and nothing to replace it had caused a backward motion. She says there is still silence about the issue of psychological health. Gist discussed the changes coming in NFPA 1500, and the other educational items being released.

The questionnaire was completed by 160 respondents from 37 states, 9 respondents did not provide state information (see table 1). All respondents represented 32,614 full time, 639 part time, 454 paid on call, and 14,161 volunteer, for a total representing 47, 868 firefighters. The smallest department represented consisted of 6 full time members, the largest was a combination department consisting of 4100 members.

Table 1
Questionnaire Response By State

ST	RR	FF	ST	RR	FF	ST	RR	FF
AL	2	97	IN	3	329	NV	1	900
AR	1	400	KS	4	712	NY	5	240
AZ	6	1,959	KY	4	267	OR	3	926
CA	3	506	LA	1	600	PA	5	500
CO	5	598	MA	3	202	TN	3	5435
CT	4	324	MD	8	19,387	TX	6	2402
DE	1	75	MI	1	43	VT	1	108
FL	7	2,513	MN	4	261	VA	2	839
GA	5	244	MO	6	1934	WA	6	513
HI	1	134	MT	1	39	WI	7	2299
IA	21	1,260	NC	1	210	WV	1	48
IL	12	685	NM	1	-	NA	9	-

ST: State
RR: Responses Received
FF: Firefighters Represented
- : Not Reported
NA: No Answer

The responses were reviewed for five primary questions; Question 12, does your department have a written behavioral health program; Question 1, does your department have a policy in place to assist members in coping with atypically stressful events; Question 3, does your department have a chaplain; Question 5, does your department provide access to an EAP; Question 8, Does your department have access to a counselor not associated with an EAP; and Question 10, Have any members of your department taken a psychological first aid course. The responses were further broken down by total responses, Midwest departments, and departments that were mostly volunteer. Midwest departments were chosen based on their proximity to Iowa and included Iowa, Kansas, Missouri, Illinois, Wisconsin, and Minnesota. The definition that

was used for volunteer agency was at least 75% of all members were volunteer, and no more than 6 members were career. This definition was based on Hiawatha's strategic plan for future staffing. See Table 2.

Table 2
Answers by group and question

Group	RR	BP		ASE		CH		EAP		CO		PFA	
		Yes	%	Yes	%	Yes	%	Yes	%	Yes	%	Yes	%
All	160	40	25.0	141	88.1	107	66.9	147	91.9	63	34.9	29	18.1
Midwest	54	10	18.5	44	81.5	37	68.5	50	92.6	15	27.8	9	16.7
Iowa	21	3	14.3	16	76.2	14	66.7	19	90.5	5	23.8	1	4.8
Vol	9	1	11.1	8	88.9	4	44.4	4	44.4	2	55.6	0	11.1

RR: Responses Received
Yes: All affirmative answers.
BP: Have behavioral health policy
ASE: Have policy on atypically stressful events
CH: Have a chaplain
CO: Have a counselor
PFA: Member has taken Psychological First Aid

Secondary questions regarding the availability of the EAP to families and volunteers and the whether the chaplain or counselor took steps to become familiar with the fire service were reviewed. These reviews were also completed for respondents from Midwest, Iowa and mostly volunteer agencies. See Table 3 and Table 4.

Table 3
Chaplain and counselor familiar with fire service

	Chaplain			Counselor		
	Tot	Familiar		Tot	Familiar	
	Yes	Yes	%	Yes	Yes	%
All	107	81	75.7	63	38	60.3
Midwest	37	27	72.9	15	11	73.3
Iowa	14	10	71.4	5	3	60.0
Vol	4	1	25.0	2	1	50.0

Tot Total number of affirmative answers to having a chaplain or counselor.
Yes Total number indicating their chaplain or counselor had taken steps to become familiar with the fire service.

Table 4
Is EAP available to families and volunteer members

	Tot	Families		Volunteers	
	Yes	Yes	%	Yes	%
All	147	107	72.8	60	40.8
Midwest	50	37	74.0	21	42.0
Iowa	19	13	68.4	9	47.4
Mostly Vol	4	1	25.0	1	25.0

Tot Total number of affirmative answers to having an EAP.
Yes Total number indicating their EAP is available to families or volunteers.

Based on literature review and SME interviews, the major components of a psychological health program should include; (a) a written policy, (b) peer support mechanism in this case staff trained in PFA, (c) mechanism for dealing with PTE/ASE (d) trained chaplains (e) trained counselors (f) an EAP available to all members and families and, (g) use of after action reviews or hot washes. The final analysis was to review all the received responses for yes answers to all questions. Only three all or mostly career fire departments met all those factors. They were located in Maryland, Minnesota, and Arizona. When you remove the training piece for chaplains and counselors, the psychological first aid training, and the after action reviews, still only 15 of the 160 departments represented are providing a comprehensive psychological health program Overall, only a portion of fire departments are providing for psychological health and wellness.

Discussion

Regardless of standards and consensus documents, a psychological health and wellness program is essential to the wellbeing of the members (International Association of Fire Fighters/International Association of Fire Chiefs, 2008). Having a comfortable workplace with good pay, benefits, feelings of safety and stability, etc. contributes to psychological health (Gist

& Taylor, 2008). In discussions and review, it became apparent that having mechanisms where employees can seek assistance as needed, and receive evidence based treatment, is in turn contributes to having a comfortable workplace.

There is much focus on the organization as a whole. Both Gist and Nash placed emphasis on the organization as a mechanism of support (Nash, 2011) (Gist & Taylor, 2008). LaDue emphasized the importance of feeling "in control". While it's obvious that there are portions of the program that deal directly with psychological health issues, it's important to note that training, leadership, cohesion, communications, and command and control, to a large part, help in the processing both stress both at atypical events and during normal operations. Responsibility for the program extends from the Chief, all the way down to the individual firefighters, and is not a stand-alone policy. Physical health and fitness builds resilience. Gist points out that the use of ICS consistently can give chaos order, which reduces operational stress. After action reviews and hot washes provide an opportunity for systemic improvements and increase level of safety, and it also puts crews in the habit of taking a time out to discuss every call, not just waiting for the big one.

Both the literature review and interviews identified specific components of a psychological health program. Nearly every source now agrees that the front line is having peer supporters trained and available to provide support to members. Those supporters should be trained in basic techniques found in a psychological first aid type course (Australian Centre for Posttraumatic Mental Health, 2011). They should be experienced members who are respected and have an approachable personality. Chaplains provide essential spiritual support and can aid in dealing with numerous issues (Nash, 2011). They can serve as a gateway also, connecting those needing support with the right resources.

The availability of both EAP's and specific mental health professionals can provide support and referral. Having a specific counselor on staff, with training and experience in working with firefighters, PTSD, stress, and anxiety can be helpful. That person can also serve as the focal point for the program, providing guidance to peer supporters and referral assistance when specialized care is needed. An EAP has limited capabilities, as pointed out by LaDue, yet EAP's can help with the other components of the program. For example EAPs used should be able to help with weight loss, smoking, alcohol and substance abuse, financial issues, families and marriage issues, and other issues that a single counselor may not have expertise in (National Fire Protection Association, 2007).

The ability to make referrals to specialized care is essential. We would want an orthopedic surgeon to treat a fracture. Dill, LaDue, and Gist all stressed making contact with those professional support mechanisms, such as EAP's and counselors and assisting them in becoming familiar with the fire service. Gist discusses the rollout of an online program to aid mental health professionals in obtaining knowledge. Making contact a head of time will allow a department to prepare, rather than respond, to a potentially traumatic event.

The questionnaire results demonstrate that fire departments are not providing full psychological support packages. Most have some mechanism for responding to stressful events. Some have chaplains; some have counselors, some EAPs with limited access for families. Even more pronounces is that most volunteers may not have access to EAPs, particularly when they are not part of a combination department. The implication of this is that fire department members do not have access to the support they need.

The implication for the Hiawatha Fire Department is that a full psychological health and wellness program needs to be established with the identified components. The implication for

the national fire service is that increased awareness efforts need to continue regarding counseling and psychological support. Dill discussed this in his interview. He endorsed all the work and products the National Fallen Firefighter Foundation is doing toward Life Safety Initiative 13, but has concerns that information needs to be out there now. Gist discusses that much of that product will be released soon. Regardless, the implication is that just like physical fitness and respiratory protection once were, attention needs to be given to psychological health.

Recommendations

The following recommendations are made for the City of Hiawatha and the Hiawatha Fire Department:

1. Adopt and implement the attached Psychological Health and Wellness Policy, including all elements identified in that policy (appendix).
2. Create a request for proposal and seek out specific EAP for HFD that includes availability to volunteer members and their immediate families, and provide funding for that purpose.
3. Seek out and recruit a mental health professional to serve as the Psychological Health Specialist for the Hiawatha Fire Department. Stipend pay should be budgeted for this position.
4. Assure that a mechanism is in place to provide training for the Psychological Health Specialist and Chaplain. This includes funding as necessary.
5. Using information gained from this research, the City should develop and adopt a psychological health and wellness policy for other city employees, including a defined process to respond to stressful events.

General Recommendations for other readers:

1. Efforts should be made through the fire service organizations to increase awareness of psychological health and wellness issues. In particular, those efforts being undertaken now must be pushed down to the state and local levels, and advocates for psychological health should be developed.
2. Fire schools and conferences should recruit instructors and speakers who are subject matter experts to provide instruction at conferences.
3. Regional fire service groups should work together to seek out funding and grants to provide psychological health and wellness programs where individual departments may be too small to provide all the services.
4. An interesting fire service study would be to compare the stress levels of firefighters against their job satisfaction and feeling of safety.
5. Another community analysis study may involve evaluating customer satisfaction levels in a communities and comparing those against perceived levels of stress within a fire department.

On review, this research tended to be difficult. While finding a respiratory protection program or fitness program policy written for a fire department is easy, finding a behavioral health and wellness program aimed at a fire department is a challenge. Many are simply based on older versions of NFPA 1500, address only EAPs, and are out of date calling for the use of CISD teams. This research was focused at high level on what should be in a behavioral health and wellness program. However, it was necessary to dig a little deeper on some topics. In particular, CISD, as evidenced from the questionnaire, is still used extensively by fire departments across the United States. Clearly, from the research, it is not an appropriate tool. People are resilient, and most of the time will process their stress at their own pace, and

ultimately return to the readiness state when given the support they need. Psychological Health and Wellness initiatives should focus on developing that resiliency and providing appropriate support when needed.

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APPENDIX A

Interview with Lisa LaDue

By Mike Nesslage

June 7, 2012 at 1:13 PM via telephone

Lisa LaDue is the Founder and former Executive Director of The National Mass Fatalities Institute. She is also an experienced Clinical Social Worker, providing consultation, training, and direct services to enhance resilience to and recovery from stress, trauma and disasters. She has been providing clinical social work and mental health services for over 30 years in diverse, cross-cultural settings. Lisa is a volunteer firefighter and has had much interaction with emergency service personnel. She was chosen as a subject matter expert because of her experience with emergency service personnel, disaster work, and her qualifications as a Clinical Social Worker.

Note: The introductory portion of this interview was not recorded. This transcript has been edited for brevity and to protect personal or confidential information. It was transcribed by Amanda Bieber.

Chief Nesslage: So I started digging around and thought that would be a really good research topic to kind of put together because it's something that's just piece meal. Not a lot of people are doing much about it. I mean we're great about telling our guys go work out and eat healthy and all those things but on the psychological side, you know the mental wellness, we're not doing much on as a fire service. So that's where I'm at.

Ms. LaDue: Ok and I would totally agree because there's been talk for years. And you know it's really, Michael, you know coming out of the fire service with critical incident stress debriefing, you know which later developed into critical incident stress management. That was really aimed at addressing that in a real peer supported way you know. And then they ran into trouble in 2000 with research showing not only did it not seem to make any difference it terms of preventing PTSD in firefighters, it sometimes was harmful.

Chief Nesslage: Right.

Ms. LaDue: And so, it's like that had just begun to gain acceptance and where it was like "Well, you're not crazy and it doesn't mean you can't do this. But maybe a debriefing might help." But then they started coming up with a bit of a black eye in their research and there hasn't strongly been anything that has come up to kind of repair that or replace it, I don't think. So, I have really felt that there has really been kind of a backward motion. Just as your saying, a lot of words given towards if you need psychological support it's ok. It's not really ok. I don't think.

Chief Nesslage: Yeah.

Ms. LaDue: Fire service, in most places, its still isn't really ok.

Chief Nesslage: Yeah and that's what I'm seeing. I guess my first question I'll go back to the first question I was going to ask you in particular. I wrote this one for you is: Now that you're in the fire service, you're a firefighter and you're on the inside, like you said climbing around cars, what kind of issues are you seeing among us that could benefit from psychological health program?"

Ms. LaDue: Well, its actually it's harder to see since I'm in the middle of it and not being able to see the forest from the trees but I know the things that have thrown me and part of my issues are unique because I do come from the mental health.

Chief Nesslage: Sure.

Ms. LaDue: We both know that, all the departments are different. And we're a small very rural department. We don't even have a town. It's that it (trauma) just isn't even addressed, that these calls could be upsetting. I remember one call where there was some concern about a new firefighter who had to do CPR and there was some concern about whether she was ok from that, nothing else, I mean you know how gruesome, it doesn't matter where you are, how gruesome some of the car wrecks are with fatalities and dismemberments. It's just not addressed. It's just there's still a silence. It's not even brought up around here that if you need help let us know. That isn't even stated.

Chief Nesslage: Right.

Ms. LaDue: And so I had an incident where it threw me off and I didn't know who to go talk to.

Chief Nesslage: Oh I see.

Ms. LaDue: And I thought well isn't that bizarre. Because I mean, I can talk to myself. I mean I do that pretty regularly but I didn't know. I had no idea who to talk to about it. And so I just talked to a couple of friends because it had to do with you know. I had, I'll just tell you real quickly. It won't take long, but I came upon - I was on my way actually to town, and came upon a fatality accident. And so you know I keep a traffic vest in my car and that kind of stuff. It was cold, about 15 degrees out that day. And I got out to make sure that they had been able to call because of a lot of dead cell zones around here. And they said yeah. And I asked if anybody was in the car. It was a single vehicle, into some big cottonwood trees. And they said yeah but there was no longer a pulse. And they had called it in and the county wanted them to start traffic control because they were concerned about having another accident. So, I said well I can help with that. Another guy, I think from another department had a vest, so we started doing traffic. And I just, you know, I don't need to go see it. A fatality's a fatality. And I was getting the street closed, directing traffic with just my vest, freezing my butt off. And suddenly someone drove up

fast and jumped out. And it was a woman and she screamed that's my husband over there. And I realized they were people that I knew pretty well.

Chief Nesslage: Oh my.

Ms. LaDue: And you know I just went numb, and I could hardly think. And my natural inclination, partly because I knew her and partly because it's my normal professional role, was to go assist her. Get her back home provide her support. I couldn't do anything because I was doing traffic control. And I couldn't figure out for several hours what really was wrong. And what was wrong for me, I think, was that I was treating it as a fatality, when in fact it was a guy that I thought really like a lot. And I felt guilty about that and that mixed role you know.

Chief Nesslage: Yeah.

Ms. LaDue: And so I think that's part of it. And that's probably unique to some extent, in the volunteer department, although not entirely. Because I have certainly talked to Cedar Rapids firefighters that have had trouble. If we are out of uniform, we lack a certain psychological barrier. I remember that from years ago, talking with a Cedar Rapids firefighter who was really thrown out of balance because of something that he had to deal with a call. And he was in street clothes and not in uniform and that really provides us with like a suit of armor psychologically. So, as volunteers, if we're forced on the scene or something like that it's easy for us to be in that position. You're in a small community too.

Chief Nesslage: Yeah.

Ms. LaDue: It could be somebody you know. Even if it's somebody you know and you respond with your crew there's a certain protectiveness about that. They don't have that if you show up without a little tools of the trade kind of.

Chief Nesslage: Yeah.

Ms. LaDue: I think that one of the unique aspects of that, I think of especially volunteer departments, because it's more likely for us, that for that to happen to us and then the silence about the fact that somebody might need support.

Chief Nesslage: Ok the thing that always gets me is a surprise.

Chief Nesslage: And then if it's somebody that I know, that throws a bigger surprise. So I can appreciate that. I can understand what you're saying there.

Ms. LaDue: Right. And I think you know a lot of times, it's part of sizing up the incident. We come up, you can you know as you approach it, your mind begins pretty quickly to try to make sense of it and anticipate what it's going to be. And then if it's not that, because our brains are wired to set things up in an orderly fashion, when it's not that - and I've done lots of work on the past few years on the whole neuroscience on this, the brain can actually kind of freeze up and it

doesn't know how to do it's normal operations of problem solving. And you know going through step by step and we have to find a way to kick us back into gear. And that actually, some training that I actually did with our department, I've done it for some DMATS as well. About not after the fact, but what do we do in those situations when we do find ourselves frozen and unable to track well when we're in such a state of fight or flight or freeze, then we can't get our brain to settle down and work right. And I think that's a new training I developed and I thinks it's critical for us to learn as firefighters and emergency responders to have skills to kind of kick start out brains back into operation when we get surprised or what's the word I want horrified.

Chief Nesslage: Does that go along with one of the things I read in my research? Is that we don't so much strive to understand something is that we try to make sense of it our brain tries to make sense of things that happen and if we can make sense of it whether we accept it or understand why it happened that's not so much as just making sense of it, is that kind of what you're saying?

Ms. LaDue: It's a little bit different, because I think that's more after the fact.

Chief Nesslage: Ok.

Ms. LaDue: But you're right, that's why I struggled so with that incident of mine. Until I could make sense of it I couldn't get ok with it.

Chief Nesslage: Ok.

Ms. LaDue: I figured out what was really bothering me about it, and then I went oh and I felt bad about it and I cried about it but I was able to let it go then and not get stuck to there.

Chief Nesslage: Oh ok.

Ms. LaDue: That's an after the fact kind of thing. And the area that I think is sort of untapped and we really have to look at are those situations that, that I've heard many, many examples of incidents during debriefings which I have done. Is showing up on scene and having something bizarre. One that sticks in my mind, Mike, was, though I have no idea what department it was, but it was a multiple fatality single vehicle incident out in the country somewhere. There was a car; I'm hesitant because I hope it's not your department. There was a car with four teenagers that had crashed out in a corn field and as they approached the vehicle the wipers were going because it was rainy and the radio was still playing. And it made for a bizarre situation that really freaked out a couple of them.

Chief Nesslage: Yeah I don't know if that was my department but I can really appreciate that and…

Ms. LaDue: Yeah

Chief Nesslage: I been doing this 29 years and I've had those weird situations and they just stick with you.

Ms. LaDue: Yeah and the problem was, at the time, at least one of them was like frozen. He couldn't think what to do until someone threw his, you know, the go bag into his hands that physically that got him going back on auto pilot. And he could go do it, but the eeriness of it just freaked his brain out for a minute. And he didn't even know what to do next and I know of other guys who couldn't do CPR because the kid reminded them of something or whatever and those are the situations that are most psychologically and physically dangerous for us. The ones we get literally stuck in. And those are the ones that are most likely to lead to PTSD and all those other problems, so those situations where we kind of get frozen even if it just for a minute or less.

Chief Nesslage: Can you summarize what you're teaching people to do about that? How to process that?

Ms. LaDue: Yeah it's real simple skills. And since I've gone yet but you know I responded to the tsunami six weeks after in Thialand and six months after to India. And then the big earthquake in China in 2008, I took another trauma team over there. And the method comes from the work we did with them, but applying them at the time. They're just real simple things, like actually you do a little bit of it when you start, when you know you've got a call you've got to go on. It's taking a moment and noticing breathing. Noticing actually what you do, and saying a prayer or you know taking a moment and getting physically centered. But what I concentrate on is having people put attention on their body, so their brain and their body are still connected and it helps keep it wired right so the brain doesn't flip out because literally the top part, the big white matter part of the brain that's involved in problem solving, and doing the things we need to figure out and being creative, it just doesn't work, just knows what to do next. That becomes disconnected if the lower brain feels freaked out and by freaked out Imean what it's doing is basically saying "this isn't safe."

Chief Nesslage: Ok

Ms. LaDue: And any of those situations that make that lower, really, kind of unconscious part side of the brain, say "you know what - this isn't safe!" it takes the body to kind of give it messages up to the brain that you're okay. Feet are on the ground, breathing is ok, I can feel something solid and it literally calms somebody immediately. It's kind of amazing

Chief Nesslage: Ok

Ms. LaDue: So it just using it's learning some skills to interrupt when the brain is freaking out and the beauty of it too is that it doesn't bother firefighters and other first responders to learn physical skills. Then it's not psychological and isn't so much, it really is the nervous system kind of operating on its own level.

Chief Nesslage: Ok

Ms. LaDue: So what I suggest Mike is that if you find some stuff on PTSD and the neural side of part of what they're learning about how to deal with that um I think you'll be pretty interested.

Chief Nesslage: the um course that you're teaching is that just something that you've done on your own and you're doing it for your department?

Ms. LaDue: Right and I've done it you know a few other places. I've actually done parts of it as part of the mass fatality training that I've done in the states of Washington, and California and Arizona, but there's a new course out. But I haven't seen it but the National Center for PTSD that is part of the VA in connection with the National Child Traumatic Stress Network. They've developed psychological first aid course and I'm a train the trainer for that. And really what I've done is modified that to some extent so it's based on evidence based practice and then thrown in some of this other stuff. But Patricia Watson, whose from the National Center for PTSD and one of the training developers and trainers of the psychological first aid course has developed a psychological first aid course for firefighters and she said she'd send it to me for me to review but I haven't gotten it from her yet but I would guess it's going to be pretty good. She is really sharp.

Chief Nesslage: I took psychological first aid course

Ms. LaDue: Ok. Because that's basically a good course. I, I just think it lacks a little they finally have included some stuff about physical pieces and they talk about that.

Chief Nesslage: Yeah.

Ms. LaDue: But they don't go quite deep enough I don't think, because in my opinion from my personal experiences and from my experiences working directly with people having suffered major trauma you know that's the missing link. Once your brain goes into overwhelm, you can't talk it out of where it's at, or think it out of where it's at. Once it gets to that point you've got to use the body to pull it out of that. Before then you can do that. Do you know how many times you've tried to talk to somebody that was you know either scared to death or really traumatized and they don't even seem to hear you?

Chief Nesslage: Yeah.

Ms. LaDue: Can't respond. That's the state I'm talking about. They can't, that part of the brain has stopped functioning at that time. So I throw in more physical pieces to supplement the psychological first aid.

Chief Nesslage: Ok.

Ms. LaDue: But when I get that from Patricia or if I see it's posted I'll let you know.

Chief Nesslage: That'd be great. And I always have to refer to my notes but the National Center for PTSD and National Child Traumatic Stress Network and the VA?

Ms. LaDue: Right.

Chief Nesslage: So um that they're working on that so I haven't seen anything on that either.

Ms. LaDue: I haven't either but I know she got it done.

Chief Nesslage: Cause actually one of my questions to you is: What should I be teaching my firefighters and you've really just answered it. But what should I be teaching my firefighters and you know my company officers, my lieutenants and captains and assistant chiefs? What kind of stuff should we be giving them to improve psychological health and mental wellness in the fire department?

Ms. LaDue: And I think it's, that it's easier and much more palatable for fire fighters and other first responders to look at uh prevention and interruption of the trauma response from a physiological point of view because it really is more physiological than it is psychological. I think we start looking at the family issues and the bigger picture you know there are other dynamics at work but working immediately with people they need to recognize how to interrupt that response. Cause it will happen to every one of us. Probably more than once. You know it's like we get these little scars and we work around them and we after a while it happens. It's so sad to see people go "You know what, I can't do this anymore." and they're done. And the problem is its ok if they're done but to go away wounded and they're not healthy that's what I get upset with. The casualties of, of the losses that really are result of not dealing with this stuff over the years is you've got a fatally wounded warrior going out now and there's nothing you can do now. I mean I can think of some paramedics over the years get so crusty and hard and I thought how terrible because they used to be really good paramedics and now they don't even care because they don't have the capacity to care anymore. That's when firefighting becomes just a job that you go in and do and get bothered because it interrupts your tv show or something you know.

Chief Nesslage: Yeah exactly that's interesting cause I wonder about the effect of accumulative stress. You know my point. I'm 46 years old and been doing this a long time and I'm beginning to feel like that you know. It's not any one event but it's a series of events.

Ms. LaDue: Yeah and I think it, I think, I even think, even for that kind of state we can work through that. I mean we can kind of clear the rocks out of the stream so it can flow again. And that's another way I look at it is like it's another rock or another boulder dropped in a stream. The stream manages to find its way around it till it gets too full of rocks and it gets dammed up or it gets totally out of its banks. And in working with the physiology, you can clear that out but that's the point that it actually goes into more therapy. You need someone to kind of work with it. But my opinion after all these years Mike is that we need to leave out some of the psychological stuff. Like you know, the uh really bad ones we do remember, we don't, you know I look back and I think oh I hope I didn't hurt anybody too badly. It isn't helpful to go through all the details of what happened. We don't need to remember that shit you know.

Chief Nesslage: Yeah I've read other experts have written that. And that some of the issue with CISD was sitting and recalling everything we saw, like the wipers clicking, little piece of brain matter that's dripping out of the…. You know those are the things that stand out in some of the stuff I've read. But on the other hand are you familiar with some people have written using post incident reviews and after action like hot washes as a positive?

Ms. LaDue: Yeah I do think that can be done. I do think that can be done if its approached from that perspective to begin with. You know and not from a blaming perspective, you know, that somebody screwed up and damnit that better not happen again but from a totally objective point, but things that maybe could have done better, how could we do these better in the future. I think those are valuable tools and people can still get some of the benefit of what we used to get out of debriefing. You do get that group perspective. You know one of the most interesting things I always enjoyed about debriefing: how people didn't know about the incident from anyone else's perspective. You only see your piece. You don't know what else was going on so when you put that whole picture together sometimes it really helps answer some questions and people feel better about it.

Chief Nesslage: Yeah I think so,

Ms. LaDue: It just has to be approached in the right manner not from that punitive perspective.

Chief Nesslage: We just started doing those about 8 months ago here.

Ms. LaDue: And what's your experience been with them?

Chief Nesslage: It's been good. They have a format they use to identify them to identify the topics to talk about. They talk about how did communications go? How um was there anything we need to work on training you? Did you have enough resources there? You know just kind of going over the call.

Ms. LaDue: Right.

Chief Nesslage: And my hope is that they see they have a continual self-improvement, but to also walk away saying ok we did everything we could do.

Ms. LaDue: Exactly.

Chief Nesslage: And just kind of processing the call from that fashion so they don't feel like... We've had a rash of dead babies here.

Ms. LaDue: No kidding I mean that makes you not even want to when your pager goes off you start having that avoidance reaction.

Chief Nesslage: Yeah you really do and that's what I really found myself doing. In fact, I missed one of then cause I just couldn't do it. I mean I had plenty of staff there. I usually respond to those critical calls. But I mean...

Ms. LaDue: And that's what you start to do. And that another piece in terms of psychological well-being allowing people to identify, I mean to recognize and, and even state their limitations and support them in not going past their limits. Um and I think that's drastically missing.

Chief Nesslage: Yeah I think so.

Ms. LaDue: You know what, you should be able to say if there's enough folks here that can do it, I don't want to do babies for a while. Or you know, somebody who's just maybe lost their spouse they don't want to go on a call that might remind them of that. We all have our limits and we need to be able to say that so that we can. So we feel like we have permission to acknowledge it even to ourselves and, and then be supported in that. I mean you did your guys a big favor by modeling that I'd say Mike.

Chief Nesslage: Well hopefully I did.

Ms. LaDue: You know if the chief can do it then it's ok for us too. That's a huge message. That's good.

Chief Nesslage: Well that was actually, that's another one of my questions is: I'm the fire chief, what kind of things can I do for the people on my department? Both there are technical things I'm sure I can do. There are probably leadership things I can do, but in your mind what kind of things can I do to improve psychological health and mental wellness on the fire department?

Ms. LaDue: Well I think the number one thing for psychological and wellbeing is and this is you know this from psychological first aid and I believe this with all of my being, the number one issue is to feel safe you know. And that's whether we're trying to calm somebody down at a scene, if were trying to make them feel safe because they obviously don't. Their brains alarms have gone offir brains gone off on alarm, and then once you helped them feel safe, the alarm quiets and they can make sense and tell you what has happened. And so that's the number one thing responders need. I mean there's a certain degree of safety we can't guarantee because of the nature of the job, but that is also what draws people to it. You know we're none of us are the type that have the you know feel like there's no risk involved or we wouldn't be doing this kind of things. So it's not that piece of it. I mean it is, as much as that you try to make sure they have all the equipment and PPTE they need so that they go out. Like our SCBAS are so old I won't, I'm not even gonna get certified in them cause I don't want to go into a place and be dependent cause I don't think they're safe.

Chief Nesslage: Yeah.

Ms. LaDue: So the equipment's safe, you know vehicles are safe. There's that piece but I think the biggest thing you can do for psychological well-being is everything you can to help them feel safe and that's in terms of not having their heads ripped off if they do something wrong. That's in terms of knowing they can come to you if they have an issue. That's modeling healthy limits so that you can stay healthy. It that's the number one thing - creating a sense of safety around your department in whatever way that takes. You know by telling them look you're volunteers, your family comes first.

Chief Nesslage: Ok

Ms. LaDue: So they know that if there's a family issue, they can come to you and say "You know things aren't going so good right now. I probably need to back off a little bit." So then you're not asking them why they're not responding to calls in front of people.

Chief Nesslage: Ok that sounds good.

Ms. LaDue: I mean it all is really pretty simple when we look at the basics of how we're wired and how to keep ourselves healthy.

Chief Nesslage: Ok if you were in my shoes I guess um you know and I am putting together a program and part of what I worry about, I worry about PTSD and the daily stresses and I also worry about the cumulative stresses. I also worry a little bit about the things that happen outside of here. I'll go back to my question I'm kinda looking what kind of thing would you for totally in a package? I mean obviously I should have a mechanism for dealing with CIS or PTSD? Um what should I look for in an EAP? Are there other things that I should have available to the guys?

Ms. LaDue: I have to admit because I don't think most EAPs understand trauma. I don't think they understand the cumulative stress really of really anybody. And it doesn't even have to be in emergency services even in like ER's what that kind of stress is like and so my bottom line is I think EAPs are of limited value. EAPs are actually set up for your 3 visits and if they think you really need long term then they try to refer you to somebody. I would look toward and you know I don't know. Does Linn County still have their CISM team going?

Chief Nesslage: Well, I called down to CMED and they told me that um Popenhagen, the Benton County sheriff…

Ms. LaDue: Ok yep.

Chief Nesslage: And Blome.

Ms. LaDue: Yeah Dennis Blome.

Chief Nesslage: Ok

Ms. LaDue: And the CISM is not including any of the physical. You know let me tell you how I've changed my debriefings. So if I do one I would start with ok something like "We've had this incident and probably the last thing any of you want to do is talk about it more, so I don't want to hear about what happened at the incident unless it's really something causing you trouble and if you have something about it though and you think it might bother someone else I want you to talk about it later. Because that's one thing about debriefing is they were getting, people were getting secondary trauma by hearing about things that they hadn't experienced. So what I want you to think about is how this incident is affecting you right now. Let's deal with how it's affecting you right now. Are you having trouble sleeping? How is your appetite? Your mood? So how's it still affecting you?" And we're gonna deal with that and then I go to some exercises. Like if someone starts getting activated, you know wound up, I'll say "Whoa, whoa, whoa, lets slow down. Take a minute. Take a couple breaths. Everybody, in fact, just lets notice your breathing. Notice your feet on the floor. Notice your chair supporting you."And you feel the energy come right back down. And then I'll go back to "Okay, so how's this affecting you right now? It's obviously still getting you all stirred up." And we might, that might be all we work on because it's how it's affecting us now that matters not what happened then. You said one of the things about PTSD is it gets everything mixed up in terms of, you mentioned the incident, and it's like it's happening right now. The brain doesn't get it filed away so that it realizes it's past and right now I'm safe. I didn't feel safe then but I'm safe now. So part of a debriefing I use to kind of keep those two things away from each other.

Chief Nesslage: Ok.

Ms. LaDue: I would try to get somebody that has the skills on kind of on call contract. To say you know if we need you will you come and instruct us? And what would it cost? Rather than having an EAP program that would cost you a lot more and be a lot less effective. I would at least say call me and I'll be there and I'll do it but there aren't too many that will do anything for free anymore.

Ms. LaDue: You know I've actually been, I've been talking to our chiefs about moving back out of ops because of well you know, this is hard work and I'm little. I don't know if we ever met but I'm a little person.

Ms. LaDue: And I've actually pulled myself off and thought hey I don't need to get hurt right now. If I'm concerned about getting hurt, even at training, then maybe I really need to think about am I being strong enough to continue doing this. We've gotten about 7 new younger, big, strong recruits lately. I'm going great because there used to be about 3 of us that could respond. And they needed me too much. So anyhow I suggest to chief that maybe I should move back in the more support role and maybe move more into the psychological support for the whole department now that people know me. They know that I know what they do, cause I can do it too and be that person for the department and that part of my role as a volunteer and if you could find somebody like that would be wonderful.

Chief Nesslage: Yeah that would make my life so much easier. I tell my perspective as fire chief

Ms. LaDue: If I had to move back to Iowa, could I give you a call Mike?

Chief Nesslage: That would be fantastic. Yeah if you ever move back I'll definitely look at that.

Ms. LaDue: That's there's got to be somebody. Sue would be great if she would do it and she might I don't know. I can bring it up to her

Chief Nesslage: Yeah and you know the thing that would really be helpful would be if I had somebody who lived close here to town.

Ms. LaDue: Yeah, I think she's in (your area.) And she um you know she's been on the CISM team for many years and so has worked with fire. You know the old time firefighters know Sue.

Chief Nesslage: Well, that was really my last question. What should I do as fire chief or how should I pull that together if I'm gonna have a program. You kinda give me the answer there. Get someone who has the skills and get them on call on a contract rather than paying the EAP so much money a year.

Ms. LaDue: Yeah, I really think that would be much better.

Chief Nesslage: Ok.

Ms. LaDue: And you know if I think of somebody else I'll just shoot you an email and let you know.

Chief Nesslage: I appreciate your time. I've taken quite a bit of your time here.

Ms. LaDue: That's quite alright I love this kind of stuff.

Chief Nesslage: That's awesome. Is it ok for me to email you?

Ms. LaDue: Yeah definitely and if you have any other questions, I don't consider myself an expert but I definitely have opinions on things.

Ms. LaDue: Well, let me know how this goes for you.

Chief Nesslage: Thank You.

Ms. LaDue: You're welcome.

APPENDIX B

Interview with Jeff Dill

By Mike Nesslage

June 6, 2012 at 10:10 AM via telephone

Battalion Chief Jeff Dill holds a Master's Degree in Counseling, is a Licensed Professional Counselor, and is currently at Palatine Rural Fire Protection District in Inverness, Illinois. He is a member of the American Counseling Association, Illinois Counseling Association, Illinois Mental health Counselors Association, Illinois Fire Chief's Association, International Association of Fire Chiefs, and Illinois Professional Firefighter's Association. He has several articles published in trade journals. He was chosen as a subject matter expert because of his experience as a firefighter, his education, and his work with counseling and suicide.

Note: The introductory portion of this interview was not recorded. This transcript has been edited for brevity and to protect personal or confidential information. It was transcribed by Amanda Bieber.

Chief Nesslage: Ok are you there

Chief Dill: I am sir.

Chief Nesslage: Very good. I'm here too. So, Um anyways that's one of things as I was reading some of your stuff and some of her stuff and some of your stuff, seems like you guys are in little better position in Illinois than what the rest of the fire service is in terms of providing psychological support and counseling services and some of that to firefighters and stuff.

Chief Dill: Well, I don't know, I don't know that we are little better off, we are more proactive. We have the tools and entities. I got into the business after Hurricane Katrina. It just there was a lot of firefighters who went down there and came back and they went to their EAP programs and counselors, and they found out that what we all know is that the counselors just don't understand our culture. So that's why I went back for my masters and became a counselor and then I started first off with Counseling Services for Fire Fighters and then last year I created Firefighter Behavioral Health Alliance.

Chief Nesslage: Right and I've looked at both of those web pages and those are good things that you are doing. You are a licensed counselor right?

Chief Dill: Yes, Correct.

Chief Nesslage: That's what I thought. I'll send you an email as a reminder but can you send me a bio so I can use that with my paper?

Chief Dill: Sure

Chief Nesslage: So my paper, my research, basically the way I, to give you some background before I start asking you the questions, I looked at the life safety initiatives.

Chief Dill: Ok.

Chief Nesslage: I was looking at the life safety initiatives and was looking at, came across the one where it says Firefighters and their families have access to counseling and psychological support.

Chief Dill: Right number 13

Chief Nesslage: 13 and I thought wow how do I do that. And that's essentially what my paper is how do we do that and how is the fire service as a whole doing and meeting with that? That's what my research is.

Chief Dill: Perfect, perfect.

Chief Nesslage: I guess you know my first question to you is in terms of providing counseling and psychological support for me as the fire chief what should that look like. I had no idea when I started this research, a little idea now but I'll let you tell me what you think and what that should look like in being able to provide that support to my crews and their families

Chief Dill: Well first off do you have an EAP?

Chief Nesslage: Interestingly enough um we had an event several months ago and one of my guys asked about and it is available to full time people, not available to part time or volunteer people so I don't have an EAP Program

Chief Dill: OK, Alright. How about a chaplain program?

Chief Nesslage: We have a uh chaplain um who's a local catholic priest

Chief Dill: Right

Chief Nesslage: And that's had some benefits but not, not a lot. It's been a positive situation but and he is so busy and he hasn't been on calls with us. He does come to meetings and he's come watched training.

Chief Dill: Right.

Chief Nesslage: But yeah.

Chief Dill: What about local counselors in the area, outside of an EAP program per se?

Chief Nesslage: Um. There are counselors around but as far as particular access to them, I don't have particular access to a counselor. There is not one that I can pick up the phone right now and say "Hey firefight Jill is having a problem here, can I refer her over to you? Can we send her over?

Chief Dill: Right, exactly. And those are the things that I preach. And how to go about - you know my first workshops were for the Philadelphia fire department and they have an EAP program. But through my interviews of hundreds and hundreds of firefighters across the US I found a couple things wrong with EAPs. At least, the beliefs and the methods. I shouldn't say something wrong, but the beliefs and the methods of the firefighters and EAPs. One is confidentiality. They don't want to go to their local departments EAP because of confidentiality. They think somehow it's going to get back to the fire station. And it might have in one case or a couple cases or so, but you know how firefighters are. Something happened in Maine, some counselor bled out some secret back to the fire service and the firefighters in California know about it later that afternoon.

Chief Nesslage: Yeah exactly.

Chief Dill: Right and so confidentiality was the other one thing. The second one was that they felt that if they go to an EAP, that it will somehow jeopardize them come promotion time.

Chief Nesslage: OK

Chief Dill: Third and one of the most valid is that counselors don't understand our culture and I have found this to be true from first-hand experience because when I went back to school after hurricane Katrina my whole intent was to become a counselor and help my local fire area firefighters.

Chief Nesslage: Ok

Chief Dill: While I was at school, I started noticing that my professors and other classmates they had no clue as to the basic terminology that I was using and you know understanding our fire service culture. And when I say fire service culture it encompasses paid on call, volunteer, career. Cause I started as a paid on call firefighter so I know how that goes. And actually I preach I feel paid on call firefighters can be more difficult because the people they work on are people they know,

Chief Nesslage: Yes

Chief Dill: And so that becomes more of a psychological disadvantage for paid on call rural fire departments

Chief Nesslage: Yeah

Chief Dill: So like I said, while I was at school counselors just didn't understand the basics. And they were teaching us that hey if you want to work with African American population then you need to understand their culture and if you want to work with Chinese people you need to understand their culture and so I stood up and said "Hey, if you want to work with firefighters you need to understand our culture cause we're a little different. And you know just our values and the way we perceive the job and the way we perceive us in the job. And one of the cultures, of course, is that if you ask for help you are showing a sign of weakness. And so we internalize. So that's why I first formed counseling services for firefighters, was to teach firefighters about behavioral health but also to teach counselors about our job and our know our terminology and know what we're saying. And that program has actually worked very well in Northern Illinois. I have done numerous workshops for counselors so that if a firefighter says "Hey I don't want to go to my EAP." They go to my website and they check and they see "Hey this person has gone through, and they deal with trauma and they have gone through Jeff's workshops so they might have some idea of what our and that you know what our culture is and what being a fire fighter is" and like I said that program has worked. And that is what I preach for fire departments because I travel all over the United States. I was just out in West Covina a couple weeks ago and I had numerous workshops scheduled. Especially next week for safety week but I got Maryland, a couple in New York state want to work with me and Florida being a workshop keynote speaker so and I am speaking at FRI in Denver in August.

Chief Nesslage: Yeah.

Chief Dill: And what I try to approach those fire departments that are new or that don't know what to do for their employees one is that Alright if you know your EAP, do you invite those counselors in to do ride time and to have dinner, get to know the people, get to know on just what the work ethic is, what the job entails so that way firefighters and lieutenants and officers. When firefighters come to them say "Hey you know I need to talk with someone." Well, now those officers they know who those EAP counselors are and the EAP counselors have some idea. And that's the same thing for the chaplain program. You invite them in say "Hey you are going to be doing some training, you are going to be doing some ride time and get to know the people. We do understand you are not there just tried to promote the bible and things like that. You are there for the psychological support." Third thing is know your outside resources. And that's why I asked you about counselors in the area. Have you gone and talked to counselors that work with trauma and do they have firefighter experience? Not maybe being on the job but dealing with firefighters. And these are three things that we need to break down that wall and that stigma. And sometimes counselors, I promote to them, they need to go knock at the front because a lot of times fire chiefs aren't going to go out and knock on your door and try to find out who you are. That is one of the biggest things that I promote and that's what's been happening here in Illinois that's been working really well.

Chief Nesslage: Okay, well that's something that as I have done my research that I am hoping to do. Is to find somebody that I can make contact with? I don't have an EAP for my volunteers and

part time staff. We have actually done a little bit of research into what that would cost to do. Basically, it involves putting someone on retainer, and I'm thinking if I'm going to put somebody on retainer I'm gonna go recruit somebody specifically that can commit to the fire department that can commit to being around on occasion, coming to meeting and training and learning you know they don't have to be a full-fledged volunteer but you know if…

Chief Dill: Exactly and that's what it takes as well as I have an article coming up in Fire Chiefs magazine in August and it's about mandatory training for officers and this is one thing that I do in my workshops. I show a picture of a two story with smoke showing and I ask a junior officer and I say okay give me a size up and they'll tell me you got smoke showing from the AP side - I'm gonna do water supply, we're doing search and rescue. These kids give me a whole list of everything. And I say "That's perfect." I say "Well here's your next scenario: a firefighter knocking at your door, been telling you he's having problems. He's been hitting the bottle recently and the other night he had a gun on his lap. What're you gonna do for him?" And they say "Well, I really don't know" and they just stutter and they fumble and they don't know what to do and that is where we need to go because of, you been I'm sure you been in the fire service awhile, you're seeing a whole different type of new breed of what I call firefighter coming into the fire service. And they, they don't have that um, that savvy that we had years ago. We were able to have second or part-time jobs that were construction or air conditioning or electricians, but these young kids are technically savvy and they're in touch with their feelings and they will let you know what their feeling.

Chief Nesslage: Yes.

Chief Dill: And if you're coming to an officer who's never had any training about things well that's a problem. And so not only do I promote that we need to, you know, know our outside resources but we need to have, as officers, the ability to talk to our members. And which is a big thing because, um let you in on a little secret that I'm sure you know, firefighters are poor communicators. We a do a great job when it comes to you know uh laughing and joking around the fire house or on ems calls and things but overall we're pretty poor in communications and so that's uh you know that's one of the things that we really work on in the workshops that I do across the United States is promote that officer in communications. I'm not trying to make them licensed counselors, but I sure as heck try to make them understand how to talk to their firefighters about things when they come and say "You know, I'm a little depressed" or maybe try to teach them about signs and symptoms because those are the big things. Cause of all of you know, I'm the only one that's collecting firefighter suicide data in the United States that I know of, and I've been told that I you know that this. You know I get these emails that say "Hey what we knew that Firefighter Williams, you know he took his life the other night. We sat around in CIS and we talked about you know what you know what we saw but none of us actually ever did anything about it you know and that the real tragedy.

Chief Nesslage: Yeah.

Chief Dill: That we sometimes, we see them and we disregard them. And sometimes uh you know we see them and we don't know what to do so we just don't do anything. And so this is where we need to change that type of culture - that not only is it ok to ask for help, but we need to stand up and say "Hey, what can I do for you even if it's just can I listen." So, cause of all of you know, I'm the only one that's collecting firefighter suicide data in the United States that I know of and I've been told that I you know that this. You know I get these emails that say "Hey, what we knew that firefighter Williams you know he took his life the other night. We sat around in CIS and we talked about you know what you know what we saw but none of actually ever did anything about it you know and that the real tragedy.

Chief Nesslage: Yeah

Chief Dill: That we sometimes we see them and we disregard them and sometimes we see them and we don't know what to do so we just don't do anything. This is where we need to change that type of culture that not only is it ok to ask for help but we need to stand up and say "Hey what can I do for you? Even if it just can I listen do you want to talk to if they tell "Hey stick it up your you know where" at least you know and say "Hey I'm here for you and hopefully if I ever have a problem you'll be here for me." And so that's what I'm trying to work on is that communications links and things like that that I work on in my workshops.

Chief Nesslage: Do you uh do you have any particular curriculum that you are using or any particular program or is it just more focused on the?

Chief Dill: It's all what I designed based on you know the counseling aspect and the fire service so it's you know it's designed by a firefighter for a firefighter.

Chief Nesslage: And it emphasizes communications and recognizing signs and symptoms?

Chief Dill: Right.

Chief Nesslage: Anything else? Basically, you answered the question I was going to ask which is: What do I need to teach my company officers? What do I need to be teaching my firefighters, you know?

Chief Dill: Yeah and that's what we go over in the workshops. And one of them is like I said is that ability to ask the straight forward questions. And so I the firefighter you know given the scenario that I described you know his first question would be "Well, did you feel like you, you wanted to kill yourself?" and you have to be that bold. You have to let them know that "Hey, this is serious. I'm going to be staying in the moment. I want to discuss and talk with you about this. Like I said we need address those things. You know, let me give you a scenario. We are at a CISD meeting, maybe there's a tragedy so we called in someone and there's a captain, maybe a lieutenant and 3 firefighters and they're sitting around and the counselor says "Well does anyone want to talk about anything?" You just came off a dual fatality and a child died and things like

this. Well, what's the likelihood of – first, you're probably still in the firefighter mode so you're not really knowing, digesting anything but what's the likelihood of the younger firefighter speaking up and saying "Hey, you know I feel bad about this." Well he's not going to because they don't want to look like a sally in front of the rest of the company and then you're looking if you don't have a buy in from upper management. The captains gonna say I don't want to say anything cause I don't want to look weak for my members.

Chief Nesslage: Yeah.

Chief Dill: And so they all sit around and say "Hey well everyone's fine" and this and that well what we're doing is we're internalizing. We're taking everything we saw on that tragedy, cause you know what, we're human beings first and we take that and we bury it in ourselves. And over time some people can handle it and become resilient and some people it takes effect into their life. And so these are things like I said it can be nipped in the bud if you have an officer or maybe even a senior firefighter that people can go to who knows how to talk to their members. And that's why like I said that's what I really promote is that communication and signs and symptoms and direct communications and using the proper terminology.

Chief Nesslage: How long is that? If I was gonna have you come here and do that? How long would you want to do? How much time would you want to spend say my volunteer department?

Chief Dill: These are 4 hour workshops and uh they are direct. And there's no doubt about it we actually we go over all the signs and symptoms. We do numerous role play that are based on real life events from firefighters that I have talked to. We do, we read firefighter suicide notes from notes that families have sent me. And just to understand that you know they wrote words you might be missing when they're talking to you. And we actually show an actual suicide on a video because this is the point - that these are your brothers and sisters that are sitting in that car or in our garage and they've taken their lives at this point. It's somewhere down the road 90 percent showed signs and symptoms and we overlooked them somehow or we didn't address them and this is their final act so that's why I show that video. And uh like I said it's pretty direct, it's been very successful like I said I schedule book very quickly across the United States.

Chief Nesslage: Yeah and it looks like it from the way you post it. Um, how overall though how do you think the fire service is doing? You're obviously busy but do you think that on the whole the fire service is getting it yet or do you think that uh we have a long ways to go?

Chief Dill: Well, no we do have a long ways to go, because this is the way I look at it. When I got into fire service in 89, when you look at physical fitness right hey it was the joke in reality and now you look at some of these the fire departments and they rival some of the gymnasiums in the neighborhood. And so now this is where we're at when it comes to behavioral and mental health. We're in that early stages and fire departments are getting it. LA wants to bring me out, LA Fire, Ney York State, their fire officer wants me to come out and instruct 430 of their uh training officers and so they're wanting to. What's been the hold up a lot of time is budget.

Chief Nesslage: Yeah.

Chief Dill: And when the tough choices are made that's where they lean to is operations. And I can't blame them. Somebody, you look at some of these rural departments, they'll have a $1000 dollar budget and things and also that is the downside of this. The positive is that you know the numerous magazines and articles and radio that I have been on because you know people want to know. The numerous fire departments that have contacted me that want to know exactly you know what's going on and things like that so. These are the positives of what happening in the fire service.

Chief Nesslage: Ok. Just out of curiosity have you ever been to Iowa you said you had been to Iowa have you ever come out and done a seminar out here?

Chief Dill: No I have not. I have not. I would love to. I just would love to. I'm just trying to pass the word along. Every time I read these suicide reports that I get and you know the pain that is inflicted in the families. And you know, I, and then the fire chief suicide you know "Gosh I wish I saw those things happening. I didn't realize it you know."

Chief Nesslage: Ok.

Chief Dill: And then of course the biggest ones are isolation, depression and um you know you just don't wake up one morning and say "Hey, I'm gonna hang myself." And things, there's steps, there's processes. Just like you know how they always say your children start smoking and they say well that's gonna lead to things and it leads to marijuana and hard drugs? Well that's what happens when it comes to the mental health aspect. It usually starts with something going on in your life. It could be PTS, it could be depression, depression you know and isolation and then finally it's how do I end this pain and you know I'm a burden to people or whatever the process is and then they just instead of you know like I said fire fighters are trained you know not to ask for help. And they're only option, way out, option out is to you know take their life. And their pain ends by taking their lives. And it's sad, it really is.

Chief Dill: Yeah that's, it's truly amazing how some people are resilient and some aren't. And same thing with PTS and which is a very valid um anxiety disorder. And I can guarantee you that every firefighter whose been on the job awhile has some form of post traumatic. You can recall some call within an instant or you see someone that looks like that victim or patient. It comes back to you, just for an instant. And when I put it in layman's terms - it's the mind fighting the body when it comes to that. It a real valid, it's a real problem. In fact, I was just reading in the newspaper this morning you know military they're always fighting that. This year there's been 155 days and they have had 154 suicides.

Chief Nesslage: Wow.

Chief Dill: You know and so they thought they were making some headway on it and and they find out now differently. So it's tough and we have those numbers. Like I said, police keep pretty good records, the military keep excellent records. What about the fire service? I challenge you, if you have a week, try and find the numbers cause…

Chief Nesslage: I have been looking for the numbers and yours are the only ones I found.

Chief Dill: I'll send you the stats I have, that I send out to people

Chief Nesslage: Ok that'd be fabulous. I have some that I took out of a Fire Chief magazine article.

Chief Dill: Oh yeah, ok those are mine, I'll send you the updated ones.

Chief Nesslage: That'd be great if you would do that.

Chief Dill: So as soon as you send me an email with your contact I will do that.

Chief Nesslage: Ok.

Chief Dill: Ok, so that uh like I said educate, I try to get out everywhere I can you know you'll never know whose life you might save.

Chief Nesslage: Yeah.

Chief Dill: And one thing I wanted to say real quick is that um I'm really promoting retirement too.

Chief Nesslage: Yeah.

Chief Dill: And that's an issue that the fire service needs to address as well because a lot of my stats show that a lot of retired firefighters have taken their lives so we work on that.

Chief Nesslage: So the transition to retirement?

Chief Dill: Exactly.

Chief Nesslage: More on the mental aspect not the financial.

Chief Dill: Yeah.

Chief Dill: And that's a valid problem we have in the fire service.

Chief Nesslage: I was flipping back through my notes here, so I'm gonna make sure I got that jotted down. I think ultimately you've answered most of my questions in one way or another.

Chief Dill: Sorry I tend to ramble. I get a little passionate about it.

Chief Nesslage: And that's what I've found. And that's good I have a total of three subject matter experts that I'm talking to: yourself, a lady named Lisa LaDue who is out in Colrado. She was actually on our CISD team here many, many years ago and then moved to Colorado. And I'm familiar with her and she actually helps on DMAT teams with counseling and just a neat lady. And then Dr. Gist. You're probably familiar with him.

Chief Dill: Yeah, I know Dr. really well.

Chief Nesslage: Yeah three of you and essentially you basically told me the same things in one way or another.

Chief Dill: Now here's my take on it. Ok uh I was at the conference last year by the National Fallen Fire Fighter's Foundation out in Baltimore. This was out there, and I'm in 100 percent agreement that they need to do some you know good studies and good surveys and things like that but that takes time and money.

Chief Nesslage: Yeah

Chief Dill: And my organization FPHA is set up for our direct contact. I believe in face to face getting out there and challenging people, their thought process. And learning some things so that they can use those applications as soon as they walk out of that classroom. And so that is you know what my portion. It's just a tool. You know there's a lot of tools out there and this is just what I believe and what I use and now are you familiar with the National Volunteer Fire Council?

Chief Nesslage: Yes I am.

Chief Dill: Saw that on my web page?

Chief Nesslage: I completed the survey.

Chief Dill: Oh, very good excellent, I appreciate that. They were surprised. They had close to 700 already.

Chief Nesslage: Oh yeah

Chief Dill: And so they were uh very very surprised at the turn out and soon as those results come back I will use them cause they asked me to write the national report.

Chief Nesslage: Ah very good.

Chief Dill: So we're in the process of writing that as well.

Chief Nesslage: I originally was gonna do a survey very similar to that and uh one of my counselors here one of my I shouldn't say counselors, one of my advisors, on my paper here he suggested that I be very careful doing that, because I could end up with some feedback, which you put some disclaimers on there about you know if you need help call these numbers.

Chief Dill: Right, that's it exactly.

Chief Nesslage: You know, they say we're not going to be able to hunt you down if you feel like killing yourself eventually and he said you probably need to be prepared for those ethical issues because if you distribute 50 questionnaires to your member sand one of them comes back and says this you're gonna have an issue with trying to hunt down that person and figure that out. So he said without having a professional to oversee you, I would caution you to proceed with that. So I elected not to go that way. I don't know if that's burying my head or just not overtaking stuff that I don't need to overtake.

Chief Dill: Right and like I said you still have to remember that suicide has the stigma in our society and people are afraid of it and uh you know FPHA one of their concerns also is the for the children of those firefighters lost.

Chief Nesslage: Yeah.

Chief Dill: And so we are setting up, as we gain our money, cause we're a not for profit, one of the things we would like to do you've heard of burn camps where children that have been burned they meet for weekend and things.

Chief Nesslage: Sure.

Chief Dill: And that's what we want to do for our children of firefighters that took their lives because the emails and the phone call that I've gotten from spouses and things, their children feel like their alienated. And they have to understand that there is a lot of kids out there who have lost their fathers, mainly fathers, to suicide so we need to make sure that they um make sure that they understand that they can network as well.

Chief Nesslage: Yeah.

Chief Dill: But um so we'll see and another things is the scholarship thing as well.

Chief Nesslage: Yeah I thought that was neat.

Chief Dill: Yeah, we're setting that up after 4 people that I've become really close with and they're named after their sons.

Chief Nesslage: Very good.

Chief Dill: So but uh yeah so that uh anything else

Chief Nesslage: No um do you mind if I email u if I have more questions?

Chief Dill: No please do.

Chief Nesslage: I will probably have some clarifying things, and I will let you know what I am going to include in my paper before I do so you can tell me hey I didn't say that or correct me or what.

Chief Dill: And as soon as I get your email and things I'll send you the updated stats.

Chief Nesslage: Yeah and anything else you think of that I might want to use I would appreciate.

Chief Dill: Ok no problem.

Chief Nesslage: Well thank you very much for your time.

Chief Dill: Hey you take care and good luck with that paper.

Chief Nesslage: Thank you. Have a safe day

Chief Dill: Thanks bye bye.

APPENDIX C

Interview with Dr. Richard Gist

By Mike Nesslage

June 7, 2012 at 2:30 PM via telephone

Richard Gist, Ph.D., is principal assistant to the director of the Kansas City (Mo.) Fire Department and a faculty member of the Department of Preventive Medicine at Kansas City University of Medicine and Biosciences. He holds an international reputation in both the emergency response and research communities as an author, researcher, lecturer, consultant and commentator on psychosocial impacts of disaster and community response to catastrophe. He was selected to be interviewed as a Subject Matter Expert based on his work with the National Fallen Firefighters Foundation and the Life Safety Initiatives.

Note: The intro portion of this interview was not recorded. This transcript has been edited for brevity and to protect personal or confidential information. It was transcribed by Amanda Bieber.

Chief Nesslage: Very good So you were giving me some background or you're getting ready to have a conference call where some stuffs at

Dr. Gist: Right, I depending on what your one of the major initiatives that one of the major things that came out of the original initiative 13 meetings was that revisions needed to be made in 1500.

Chief Nesslage: I recognize that when I read 1500 the other day there is a lot there that's not…

Dr. Gist: Those will be voted on on Thursday a week from today in Vegas.

Chief Nesslage: Ok

Dr. Gist: They have been endorsed twice unanimously by the technical committee so it is uh while it is highly unlikely that uh either the two notions to go back to the way it used to be are likely to succeed. Thursday I am going to out to Vegas to make sure I am there to talk about it and you know we're simply not pushing anything out until that's done.

Chief Nesslage: Ok

Dr. Gist: Obvious reasons there are a number of things that so have you received any of the papers that have flow charts in them about the proposed approach to dealing with this?

Chief Nesslage: Yes, in fact, I don't have that in front of me cause I am at my fire station office, yeah I think I know what you're talking about the flow chart about you follow up with the TSQ. Do they need assistance and then…

Dr. Gist: All those things you know are, every one of those things is readying up for release. There's a CE package on company level after accident review. It's in final production now. It'll available to fire departments and they'll be rolling that out at FRI this year.

Chief Nesslage: Ok

Dr. Gist: And while it really had its origin in behavioral health program, we're pushing it out as a component of Initiative 1. Which is the culture of safety because it's a foundational piece that is much, much broader and deals with this as the military approach to what they'd like to local learning level review of all operations even as standard operation the tagline coming out of the foundation will be "Every time you turn a wheel. "

Chief Nesslage: Ok

Dr. Gist: Its five basic questions about: What we really set out to do? What did we actually encounter? What went well? What could've gone better? Who should we tell what we learned?

Chief Nesslage: Ok

Dr. Gist: And it's to set a habit that you have that discussion even if you're just gonna go out to dumpster fire and demonstrate one more time that garbage will not burn while submerged. If you still do that review then when everything goes to hell in a hand basket, what's the first thing you're gonna do? You're gonna have that conversation. Have a way to have that conversation that's routine and not threatening and flows automatically. Just as it took us about 20 years to get the four basic principles of IMS to flow that automatically. That if you wrote that the first thing you do on a dumpster fire even though all you do is fill the dumpster with water, if the first thing you do is establish command oh, give me just a second, just one more minute here. (other phone conversation)

Dr. Gist: But anyway what I was saying here is that if the first thing you do on a dumpster fire establish command, broadcast your assessment, assign your resources and project your resource needs when you walk into a place where you know all hell is breaking loose and you know the first that you know every single word that always passes through your mind when you walk in there. In this case it's gonna be a verb instead of a noun and uh when all that's coming on what you know what are you likely to do. If you always do that every time then what you will default to is that basic set of principles. It won't change the nature of the event. It would, proven that again and again. In fact up in your neck of the woods our original research on this really got uh was strong and a lot to the United Airlines crash back in the 80's in Sioux City. If you go over the tape of that, when the airplane actually hits the ground you'll hear everything start to go through the roof, tension lines, and one thing that changes the whole event is you'll hear Bob Hamilton's voice from downtown and all he says is "What have you got out there, Orville? And at that point, Deputy Tealy goes immediately into those 4 principles and the whole game is different. So, just as we have spent 20 years getting that in ICS, this is really an element of

closing the loop now and getting the same regulatory to having that discussion. Even if everything went well, just verifying for ourselves what we did and why it went well and discussing what we might do differently because when the accident enters the HVAC then we will revert to that when we handle things. It will make a difference. The second piece also just about to come out, I've been talking to them about that this morning, cause it came out from a sideways track in our community services meeting this morning. Cause the guys want to get their hands on the product is a thing that will be entitled Curbside Manner. And what it is, it's a 5 principle simple way of dealing with all people you come in encounter with in a way that basically defuses some of the stress of that citizens emergency. This same 5 principles that underlie the stress first aid program that we've adopted form the navy and marine corps. It will be the basis for uh you know dealing with occupational stress matters coming out. And that adaption is done, it's in final production as well. So as you see as this thing starts to flow, the idea over the next year is to roll out a series of products that begin with the very foundational stuff that is good to do in every situation. Then it's a drill down. As you go down through the so that whatever else is needed is available and available in the appropriate venue, down to the specificity that if you have to get 2 referrals for clinical reactivity, which is relatively rare despite what you may have heard in the dog and pony show. The the odds of getting hit like a truck by an event and not having it resolve naturally in a couple of weeks is not huge. It happens regularly but it really depends on what else is going on in your life at that time.

Chief Nesslage: Ok

Dr. Gist: And the vulnerabilities the individuals provides. And what the evidence tells us now is that rather to make them sit in a circle and revisit the stuff that's eating them alive, what we need to do is get them into a therapeutic relationship to really deal with it. So the second set of changes in 1500 are to chapter 11 and those chapter will go through with that objective. The changes in chapter 11 actually redesign what a member assistance program is by stating specifically the services it needs to be able to provide and the level at which it needs to be able to provide them. And then we developed a set of materials that your EAP and MAP provider can access to teach them excellent evidence based techniques to use without having to take two days or pay 500 dollars to go to school somewhere.

Chief Nesslage: Ok

Dr. Gist: In other words the medical university of South Carolina, they're able to access an online accident reviews used to the military and like child abuse providers and people. I have very well tested that will teach them the very best current approaches for dealing with PTSD anxiety and depression. So that even if you're uh employee assistance provider is somebody at your local mental health center, is somebody who said "I'll take that on. Send me somebody if you ever have them." Well, if they need to bone up in a hurry on what's the best thing to do with a firefighter, they're gonna have by August an incredibly good online program that they can log into at midnight and sit at their kitchen table if they'd like and learn a technique, you know, some

technique things that will not only be good for firefighter but all kinds of other people they serve. Will help them understand how to use it when dealing with firefighters, ems people. So whole idea here is to build a series of programs that not only are the very lasts in evidence based stuff, they hit all levels of the organization appropriate to the overall goals involved in. More importantly there is no cottage industry involved in delivering them. Nobody make a dime. As the evidence changes, the programs can change. So although they've been quiet gently quiet about it to roll out time. uh This is in occupational behavioral health one of the biggest things that anybody's ever tried to do in that it's one of the first real cases of translating high level research to street level practice.

Chief Nesslage: And that's what I've found is that there's a ton of stuff out there but there's nothing it's not really brought together, except for the stuff that you guys have done. So far there's not been a lot of research brought together. Now the uh Marine Corps, Navy, Department of the Navy has some stuff that's recent.

Dr. Gist: Yes and that's the stuff that we hired the national center to rework a lot of it using a focus group of guys connected with the uh um, member assistance programs and like see FDNY, , Hondo, Prince William, Eugene, Oregon, couple of other places and to work with them and to that material you see you're seeing what is called COSFA.

Chief Nesslage: Yeah

Dr. Gist: Combat Operation Stress First Aid

Yes I was trying to remember. Yes, I have seen that.

Dr. Gist: There is a version of that designed specifically for firefighters that will be available by the end of the year.

Chief Nesslage: Wow, that's excellent.

Dr. Gist: It'll look well not just like because obviously combat deployment and daily firefighting have significant differences but it's the same level, same design, same approach and part of rationale was to find the best stuff out there and then put it in a language we can utilize this industry and deliver it through vehicles that can get to the street level of this industry.

Chief Nesslage: Ok

Dr. Gist: So that uh it will be I think we have scheduled for maybe September a series of briefs train the trainers on this that will then put uh trainers in each region to be teaching that project you know when state fire schools you know trade conferences but to get it down to the local and regional level to delivery but unlike the um and see it's connected Curbside Manner product I was talking about before.

Chief Nesslage: Yes

Dr. Gist: The idea is that if your using the basics of that every day in your contact with your ordinary citizen or patient then when something happens to us what is your first default response gonna be

Chief Nesslage: To do exactly that.

Dr. Gist: Right like you treat a patient.

Chief Nesslage: Just like if the guy started having chest pain, we would do what we would do for joe community.

Dr. Gist: You know that's as close to the exact example in we used that is we took you treat firefighters broken leg any differently than you treat a citizens broken leg. It's the same basic principle but we have to apply it under different circumstances. Same thing here. So if you do that then doing the things that are in COSFA will be very easy to you because the principles you are using every day were derived from and directly linked to COSFA.

Chief Nesslage: Ok

Dr. Gist: So the subtitle for Curbside Manner is Stress First Aid for the street.

Chief Nesslage: Ok

Dr. Gist: And so as you can see here there is a lot of human factors in engineering what went for this in order to get it to the level that uh you know none of this counts for anything unless somebody in a department like yours can pick it up and use it without uh having to spend a ton of money, go away for any length of time, create a whole new organization or anything like that. If we do it right, it should be able to be the right people, interconnect into your organization, should be able to get at it easily and simply. And more importantly, rather than try to apply some standard product, they should be able to adapt that to the needs of their organization and people. So it's teaching them skills instead of techniques.

Chief Nesslage: Yeah which is exactly what my fire department is a very small combination department. 50 volunteers, you know were not unlike some of the suburban departments around you guys. Very similar you know suburban departments. But we're mostly volunteer. I can't afford to spend a lot of money. There's no way I can hire a licensed therapist solely on my staff. So some of these answers you are giving me are good answers cause they're gonna help me implement this without spending a lot of money.

Dr. Gist: In fact, if you've got a mental health provider that's willing to take any case you might have or send what they're gonna have is huge amounts of support material. One of the things was help USC secure a AFG FPS grant to do that project. That we just applied this year for one to train clinicians in uh screening and assessment. But the advantage is that not only will it teach

them the things they need to know to deal with firefighters but with Curbside Manner its important stuff they can use in their daily practice every day so the connection to them for you becomes stronger. Working with you is good for them.

Chief Nesslage: Yeah ok

Dr. Gist: And they get good stuff by being associated with you and that's an important bond to have with a provider,

Chief Nesslage: Ok

Dr. Gist: Especially if you don't have a lot of money to throw their way you need an incentive there and the notion that you'll work with me and we'll provide you with access to top quality free training that's a pretty nice deal.

Chief Nesslage: Yeah it is its well its exciting stuff and you've answered a lot of my questions already just by walking through the topics so

Dr. Gist: There's some other things let me just go down a quick list of stuff and see if you found it elsewhere or if I need to just email it to you.

Chief Nesslage: Ok

Dr. Gist: For one thing the beta version of the AAR products was uh in a fire engineering university insert the October Fire Engineering about a year ago did you happen to cover that?

Chief Nesslage: No I have not found that one

Dr. Gist: I will send that to you

Chief Nesslage: Thank you

Dr. Gist: Title is Changing the Culture of Safety or something like that but again uh this is a product we did not want to deploy as behavioral health because that would be the kiss of death.

Chief Nesslage: I will tell you the interesting thing is that after I came home from the academy I don't know why I decided to start doing this but I implemented a post incident review system within the FD that is very similar to what you are talking about.

Dr. Gist: You know what the end result of that is that you will do more to improve their safety and performance than by anything else you could possibly do. Um the reason we went for that early on is that it has been so powerful in military culture and uh and terms of how they do it for moving supplies from the warehouse to a train car.

Chief Nesslage: Yeah

Dr. Gist: The net result is that if you are always looking for um ways to improve your basic operations and always trying to communicate those findings to from the local level through the organization in a useful way there is nothing you can do better.

Chief Nesslage: Good they do that in the nuclear industry too. I have a nuclear plant about 6 miles from here and they do the same kind of after action review on almost everything.

Dr. Gist: The net result of it is that you also get people on focused on thinking about the implications of what they are doing every time they go. And if you look at what the biggest killers are in the industry outside of cardiovascular disease and things like that when it comes to the things that lead to traumatic death in the industry and fire grounds they ultimately relate to situational awareness, now what we sometimes call in our organization “IWHUA”

Chief Nesslage: Go ahead and tell me what that is.

Dr. Gist: It was Head Up Ass. It means that you go into something thinking I’ve done this before. There’s nothing that could possibly happen and then when something doesn’t go the way you expected it catches you, like the French pilot that were on the news last night.

Chief Nesslage: I missed that apparently.

Dr. Gist: It was going on and by the time you figure it out, you’ve run out of time to do something about it. Well if you are always thinking as a basic fundamental lines that every time you do something, if there’s some place this could’ve gone wrong, is there something we might’ve, we should’ve done differently to make sure it never does your always gonna have that in your head on any operation you take on and assist and heighten situational awareness and that’s probably the biggest side effect of doing consistent review. It changes the way you think about the things .

Chief Nesslage: Ok

Dr. Gist: Um for those of us who have you know old school medical backgrounds if you will this is hammered into you your freshmen year. It’s the very first thing you would present you with is to say Zebra in the ER with you know prominent sore throat is all the things it might be.

Chief Nesslage: K

Dr. Gist: And you know what you’re told is that if you find hay look for horses, but if you don’t find a horse start looking for a zebra.

Chief Nesslage: Zebra, yeah.

Dr. Gist: So zebras are always in your mind even when you see the horse. You know they can get our guys to think about that their basic maneuvers, they’ll keep themselves a lot safer. It’s not

telling them never to take a risk - this is a risk taking business, but never take a risk you didn't intend to take

Chief Nesslage: Ok

Dr. Gist: And never intend to take a risk that you don't have a damn good reason to be taking.

Chief Nesslage: Right, right.

Dr. Gist: Okay, so I'll send you that piece. Did you find the report from the risk section in Baltimore.

Chief Nesslage: Yes I got both the white paper and the summary paper on the suicides.

Dr. Gist: I'll go ahead and send it you and if you already have it you don't have to worry about it. But what it is, is the technical report on the first consensus meeting.

Chief Nesslage: Ok

Dr. Gist: That's where the flow chart developed and the basic plan of attack went on that, slide set from last year's Redmond symposium.

Chief Nesslage: Ok

Dr. Gist: It goes over the whole status of the um the initiative as of last August.

Chief Nesslage: Okay

Dr. Gist: And those things will give you a lot of background contained in them. I will also send you. maybe you could have it was on Initiative 13 at one time I think, but a paper that should be coming out here may already be out you know uh it's the Oklahoma States journal called International Journal of Firefighting Leadership. But there's a paper in that that outlines the initiative and it history. The value of those, you said you haven't written a paper in a while, the value of those is that the reference lists are exhaustive so when you are looking at things you want to more about you will have the references to guide you to them.

Chief Nesslage: Ok

Dr. Gist: And that will help simplify your research process greatly.

Chief Nesslage: Very well, thank you.

Dr. Gist: Um and basic thing in learning and writing these papers - look at what other people have detailed academic treatments, other people have written about the topic and uh make good use of their reference lists. That's why we put them at the end of articles.

Chief Nesslage: Yeah

Dr. Gist: So we'll have that for you and then once you get these things in your hand we'll also be able to uh note for you that. Anything now that strikes you as you get further into your writing process you've got my phone number you know where I am, feel free to call. We're here for as many people as possible to become aware of this. Use it, talk about, give us feedback on it and this is gonna make it work over time.

Chief Nesslage: Ok very well

Dr. Gist: So what I'll do is, I will send you an email with those attachments on it immediately we are email linking are there other questions you have that we haven't answered in this conversation.

Chief Nesslage: You know you really covered them indirectly if not directly.

Dr. Gist: If you come up with other shoot me an email or call

Chief Nesslage: Ok I will do that

Dr. Gist: You are encouraged and invited to do that.

Chief Nesslage: Ok I will do that and I appreciate the assistance that you've given me so far.

Dr. Gist: Absolutely it's our pleasure.

Chief Nesslage: I think I can probably find a bio of you online but if you don't' mind sending me a bio.

Dr. Gist: I'm sure I can find one and quickly attached to the file

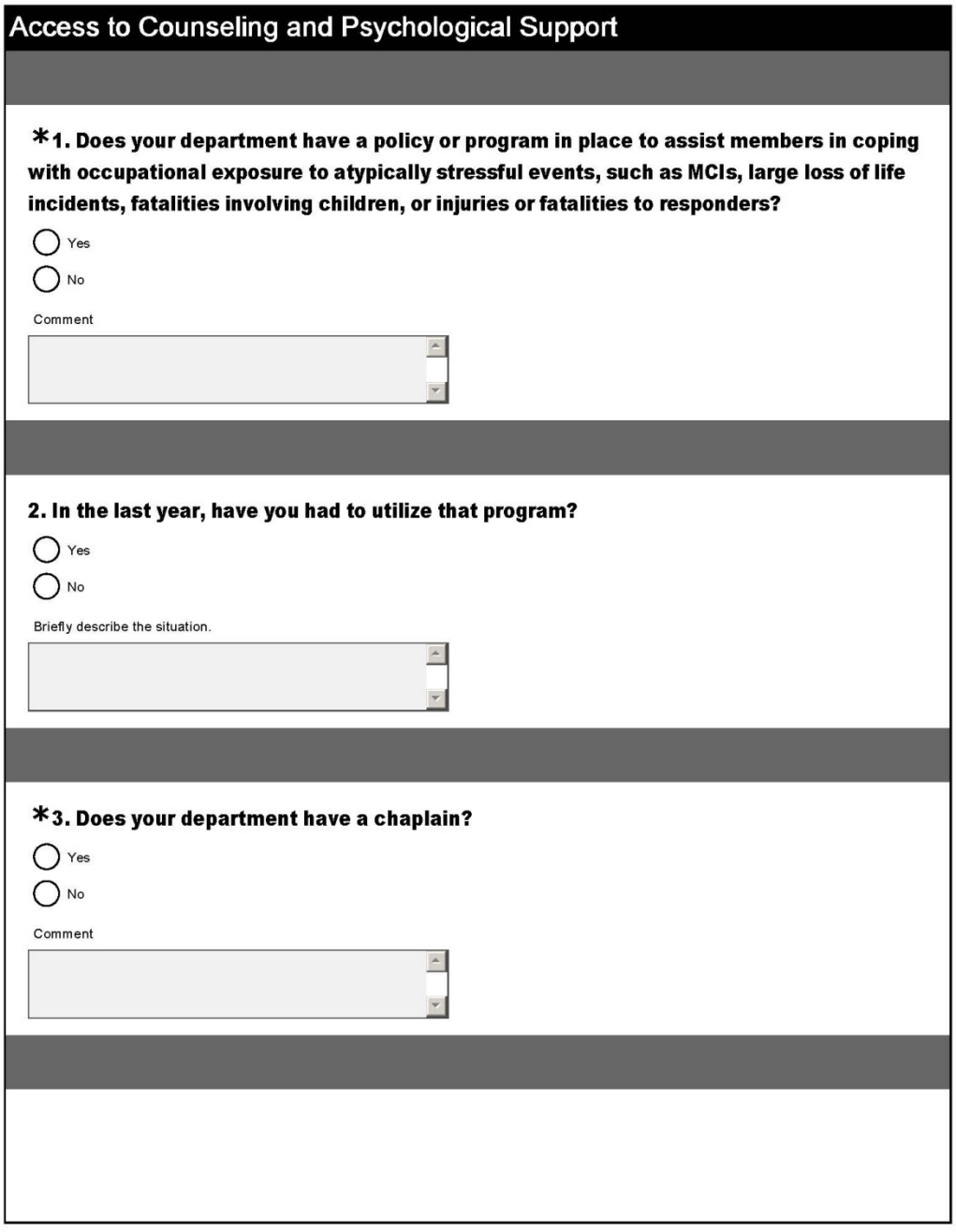
Chief Nesslage: Yeah that'd be nice. I have to that you know how that works with the SME's.

Dr. Gist: I know that and will make that happen.

Chief Nesslage: Ok thanks for your time.

Dr. Gist: Thanks

APPENDIX D



Access to Counseling and Psychological Support

***1. Does your department have a policy or program in place to assist members in coping with occupational exposure to atypically stressful events, such as MCIs, large loss of life incidents, fatalities involving children, or injuries or fatalities to responders?**

- ◯ Yes
- ◯ No

Comment

2. In the last year, have you had to utilize that program?

- ◯ Yes
- ◯ No

Briefly describe the situation.

***3. Does your department have a chaplain?**

- ◯ Yes
- ◯ No

Comment

Page 1

Access to Counseling and Psychological Support

4. Has your chaplain taken steps (such as doing ride alongs, attending fire training, or attending fire chaplaincy training) to increase familiarity with the fire service?

- ◯ Yes
- ◯ No

Comment

***5. Does your department provide free access to an Employee Assistance Program (EAP)?**

- ◯ Yes
- ◯ No

Comment

6. Does your EAP allow immediate families to utilize the program for free?

- ◯ Yes
- ◯ No
- ◯ Not sure

Comment

Access to Counseling and Psychological Support

7. Is your EAP available to part time, paid on call, or volunteer members?

- ◯ Yes
- ◯ No
- ◯ We only have full time staff
- ◯ Not Sure

Comment

***8. Does your department have access to a specific counselor or behavioral health specialist not associated with an EAP?**

- ☐ Yes
- ☐ No

Comment

9. Has the counselor or behavioral health specialist taken steps (such as ride along, attending responder training, or attending specific firefighter counseling training) to become familiar with fire service?

- ◯ Yes
- ◯ No

Comment

Access to Counseling and Psychological Support

***10. Have any members of your department taken a Psychological First Aid course?**

- ◯ Yes
- ◯ No
- ◯ Not Sure

Comment

***11. Does your department have a formal written behavioral health and wellness program?**

- ◯ Yes
- ◯ No

Comment

***12. Does your agency have a written policy regarding alcoholism, substance abuse, and other behavioral conditions that affect performance and/or fitness for duty?**

- ◯ Yes
- ◯ No

Comment

***13. Does your department have a policy mandating the use of a hot wash, after action review, or other post incident review on routine calls?**

- ◯ Yes
- ◯ No

Comment

Demographics

Thank you! Please answer the following demographic information to assist me in sorting the results.

Access to Counseling and Psychological Support

***14. Please provide your state.**

State:

15. Approximately how many firefighters do you have?

Full time

Part Time

Paid on call

Volunteer

16. Optional: Name and Department

Name: Optional

Department: Optional

17. Do you have any comments regarding behavioral health and counseling, or this questionaire, that you would like to add?

APPENDIX E

Survey Response

Demograpics

RespondentID	CollectorID	StartDate	STATE	FT	PT	POC	VOL
1915658140	28302627	07/16/2012	MO	32	0	0	12
1915315875	28302627	07/16/2012	MO	10			200
1913922663	28302627	07/13/2012	MD	1100			3000
1912328089	28302627	07/12/2012	UT	75	3		30
1908872233	28302627	07/10/2012	MO	1400			
1908342267	28302627	07/10/2012	FL	1500	0	0	45
1908006310	28302627	07/09/2012	GA	55			
1907993946	28302627	07/09/2012	OH	41	0	0	0
1907695123	28302627	07/09/2012	FL	145	0	0	0
1907470517	28302627	07/09/2012	KY	46			
1907467620	28302627	07/09/2012	IA	32			
1907460721	28302627	07/09/2012	MA	53	0	0	0
1907442672	28302627	07/09/2012	IA	28	0	0	0
1907409596	28302627	07/09/2012	KY	30			4
1906762815	28302627	07/08/2012	AZ	80			
1906716692	28302627	07/08/2012	MD	1200	0	0	1000
1906711966	28302627	07/08/2012	MD	1050	0	0	3000
1906698583	28302627	07/08/2012					
1906545507	28302627	07/08/2012	AL	1	16	40	
1906448017	28302627	07/05/2012	CT	35			65
1906136402	28302627	07/07/2012	MD	1250			1000
1906024593	28302627	07/07/2012	HI	134			
1905757817	28302627	07/06/2012	MT	15		24	
1905748282	28302627	07/06/2012	IA	4	4	32	
1905530039	28302627	07/06/2012	IA	5		30	4
1905330741	28302627	07/06/2012	KS	140	0	0	0
1905290313	28302627	07/06/2012	IL	6			
1905284615	28302627	07/06/2012	IA	8		25	
1905267565	28302627	07/06/2012	IA	99			
1905255052	28302627	07/06/2012	MA	52	0	0	0
1905250154	28302627	07/06/2012	NC	100	40		70
1905233300	28302627	07/06/2012	MD	131			
1905230336	28302627	07/06/2012	AR	400	0	0	0
1904859006	28302627	07/06/2012	MD	1054	1	1	400
1904856408	28302627	07/06/2012	IA	33	5	5	0
1904754688	28302627	07/06/2012	IA	37			
1904745846	28302627	07/05/2012	IL				52
1904727019	28302627	07/05/2012	WI			49	
1904654588	28302627	07/05/2012	IA	10	45		
1904651253	28302627	07/05/2012	TN	1800	0	0	0
1904635270	28302627	07/05/2012	MN	11	0	44	0

RespondentID	CollectorID	StartDate	STATE	FT	PT	POC	VOL
1904630497	28302627	07/05/2012	OR	325			70
1904616314	28302627	07/05/2012	CO	16			20
1904610138	28302627	07/05/2012	IA	52		38	
1904609435	28302627	07/05/2012	WA	10			20
1904593422	28302627	07/05/2012	CO	65			
1904591477	28302627	07/05/2012					
1904587789	28302627	07/05/2012	IA	31			
1904568530	28302627	07/05/2012	IN	154	0	0	0
1904496889	28302627	07/05/2012	VA	435			20
1904495859	28302627	07/05/2012	TX	195			20
1904492339	28302627	07/05/2012	DE				75
1904481393	28302627	07/05/2012	WI	65			
1904476433	28302627	07/05/2012					
1904450625	28302627	07/05/2012	CA	71			
1904444254	28302627	07/05/2012	SC	120	0	0	0
1904436112	28302627	07/05/2012	CO	300			
1904429201	28302627	07/05/2012	MI	10		33	
1904427063	28302627	07/05/2012	WI	100			
1904411390	28302627	07/05/2012	TX	1850			
1904403439	28302627	07/05/2012	OH	1	52	0	0
1904402787	28302627	07/05/2012	PA	1			149
1904402594	28302627	07/05/2012	IA	132			
1904400706	28302627	07/05/2012	NY	37			15
1904398604	28302627	07/05/2012	WI	1000			
1904389461	28302627	07/05/2012	IA	1			33
1904385068	28302627	07/05/2012	IA	3			24
1904385064	28302627	07/05/2012	AZ	157	0	0	0
1904383353	28302627	07/05/2012	MO	147			
1904381548	28302627	07/05/2012	NY	2	0	0	125
1904376951	28302627	07/05/2012	CT	133	0	0	0
1904368725	28302627	07/05/2012	OH				40
1904363017	28302627	07/05/2012	PA	2	14	0	80
1904362016	28302627	07/05/2012	MD	1200			1000
1904358384	28302627	07/05/2012	NY	389			
1904355510	28302627	07/05/2012	IA	31	30		
1904352897	28302627	07/05/2012	CO	54			15
1904349906	28302627	07/05/2012	CT	1			35
1904348819	28302627	07/05/2012	NY	16			
1904335036	28302627	07/05/2012	MD	1000			2000
1904331543	28302627	07/05/2012	IA	270	0	0	0
1904324759	28302627	07/05/2012	TX	30	10	0	10
1904324505	28302627	07/05/2012	WA	120	0	0	0
1904319409	28302627	07/05/2012	FL	27	0	0	15
1904319273	28302627	07/05/2012	TX	150			
1904318605	28302627	07/05/2012	PA	0	0	0	75
1904313864	28302627	07/05/2012	AL	29	9	2	0
1904312626	28302627	07/05/2012	IL	22	0	0	0

RespondentID	CollectorID	StartDate	STATE	FT	PT	POC	VOL
1904301746	28302627	07/05/2012	IL	92			
1904300770	28302627	07/05/2012	NM				
1904300755	28302627	07/05/2012	AZ	83	0	0	0
1904300309	28302627	07/05/2012	IN	51			
1904296454	28302627	07/05/2012	FL	500	0	0	0
1904295854	28302627	07/05/2012	KS	450	0	0	0
1904295249	28302627	07/05/2012	OR	350			70
1904293027	28302627	07/05/2012	WA	15			75
1904291866	28302627	07/05/2012					
1904287446	28302627	07/05/2012	WV	48	0	0	0
1904286575	28302627	07/05/2012	KY	50	0	0	0
1904279408	28302627	07/05/2012	MO	30			
1904276843	28302627	07/05/2012	FL	176			
1904275067	28302627	07/05/2012	GA	54			
1904271936	28302627	07/05/2012	IL	40	25	0	0
1904270775	28302627	07/05/2012	CA	230	0	0	0
1904265184	28302627	07/05/2012					
1904264039	28302627	07/05/2012					
1904263430	28302627	07/05/2012	IA	22		8	
1904261816	28302627	07/05/2012	IL	35	18		
1904261793	28302627	07/05/2012	IL	15	40	0	0
1904259815	28302627	07/05/2012	PA	140			
1904259581	28302627	07/05/2012	AZ	1500	0	0	0
1904254602	28302627	07/05/2012	OH	17	0	11	0
1904254408	28302627	07/05/2012	OH	21	57	0	0
1904253463	28302627	07/05/2012					
1904245655	28302627	07/05/2012	KY	45	2		90
1904244310	28302627	07/05/2012	CT				55
1904244281	28302627	07/05/2012	IA	8	5	18	
1904243888	28302627	07/05/2012	GA	44			
1904243530	28302627	07/05/2012	TX	20	20	0	20
1904232583	28302627	07/05/2012	WI	0	4	38	0
1904231390	28302627	07/05/2012	CA	0	0	0	205
1904229487	28302627	07/05/2012	IL	75			
1904229482	28302627	07/05/2012	FL	24	40	0	0
1904229184	28302627	07/05/2012	MN	39			
1904225855	28302627	07/05/2012	IA	44	0	0	0
1904225054	28302627	07/05/2012	PA	9	20		10
1904223257	28302627	07/05/2012	WA	30			
1904222258	28302627	07/05/2012	CO	128	0	0	0
1904221615	28302627	07/05/2012	KS	70			
1904220797	28302627	07/05/2012	AZ	53	12	2	
1904220783	28302627	07/05/2012	WA	81	12		50
1904217643	28302627	07/05/2012	IL	39	35		
1904217461	28302627	07/05/2012	IA	55	0	0	0
1904217349	28302627	07/05/2012	WI	951			
1904215444	28302627	07/05/2012	TN	1785			

RespondentID	CollectorID	StartDate	STATE	FT	PT	POC	VOL
1904214893	28302627	07/05/2012	TX	77			
1904214098	28302627	07/05/2012	IL	100	0	0	0
1904212318	28302627	07/05/2012	LA	600			
1904211574	28302627	07/05/2012	MO	97	0	0	6
1904211268	28302627	07/05/2012					
1904211018	28302627	07/05/2012					
1904210879	28302627	07/05/2012	IN	33	91		
1904208878	28302627	07/05/2012	NY	0	0	0	175
1904208772	28302627	07/05/2012	FL	41			
1904207074	28302627	07/05/2012	GA	34	0	0	2
1904206323	28302627	07/05/2012	IA	27	22		
1904205759	28302627	07/05/2012	NV	650			250
1904205672	28302627	07/05/2012	OR	66			45
1904205015	28302627	07/05/2012	KS	52			
1904204747	28302627	07/05/2012	MN	69	1	0	0
1904204616	28302627	07/05/2012	TN	1850			
1904204218	28302627	07/05/2012	IL	57	0	12	0
1904203771	28302627	07/05/2012	WI	92	0	0	0
1904203370	28302627	07/05/2012	IL	22			
1904203022	28302627	07/05/2012	GA	55			
1904199519	28302627	07/05/2012	VA	28	6	0	350
1904162479	28302627	07/05/2012	MN	97	0	0	0
1904079181	28302627	07/05/2012	AZ	72	0	0	0
1904064875	28302627	07/05/2012	WA	75	0	20	5
1904044615	28302627	07/05/2012	MA	45	0	22	30

Survey Responses, Questions 1-7

RespondentID	Q1	Q2	Q3	Q4	Q5	Q6	Q7
1915658140	Yes	No	Yes	No	Yes	Yes	Yes
1915315875	Yes	No	No		Yes	Yes	Yes
1913922663	Yes	No	Yes	Yes	Yes	Not sure	Full Time
1912328089	Yes	Yes	Yes	Yes	Yes	Yes	Yes
1908872233	Yes	No	Yes	No	Yes	Yes	Not Sure
1908342267	Yes	No	Yes	Yes	Yes	Yes	Full Time
1908006310	Yes	Yes	Yes	Yes	Yes	Yes	Full Time
1907993946	Yes	No	No		Yes	Yes	Full Time
1907695123	Yes	No	Yes	Yes	Yes	Yes	Full Time
1907470517	Yes	No	Yes	Yes	Yes	Yes	Full Time
1907467620	Yes	No	Yes		Yes	Yes	Full Time
1907460721	Yes	No	No		Yes	Yes	Full Time
1907409596	Yes	No	No		Yes	Yes	Yes
1906762815	Yes	Yes	Yes	Yes	Yes	No	Full Time
1906716692	Yes	No	Yes		Yes	Yes	Not Sure
1906711966	Yes	No	Yes	No	Yes	Yes	Full Time
1906698583	Yes	No	Yes	Yes	Yes	Not	Not Sure

RespondentID	Q1	Q2	Q3	Q4	Q5	Q6	Q7
1906545507	Yes	Yes	Yes	Yes	No		
1906448017	Yes	No	Yes	Yes	Yes	Yes	Yes
1906136402	Yes	No	Yes	No	Yes	Yes	No
1906024593	Yes	No	Yes	No	Yes	Not sure	Full Time
1905757817	Yes	Yes	Yes	Yes	Yes	Yes	Yes
1905748282	No		Yes	No	Yes	Yes	No
1905530039	Yes	Yes	No		Yes	Yes	Yes
1905330741	Yes	No	Yes	No	Yes		Full Time
1905290313	Yes	No	Yes	Yes	Yes	Yes	Full Time
1905284615	Yes	No	Yes	Yes	Yes	Yes	Yes
1905267565	Yes	Yes	Yes	Yes	Yes	Yes	Full Time
1905255052	Yes	No	No		Yes	Yes	Full Time
1905250154	Yes	No	No		Yes	Yes	Yes
1905233300	Yes	No	Yes	Yes	Yes	Yes	Full Time
1905230336	Yes	No	No		Yes	Not sure	Full Time
1904859006	Yes	Yes	Yes	Yes	Yes	Yes	Yes
1904856408	Yes	No	No		Yes	Yes	Yes
1904754688	No		Yes	Yes	Yes	Not sure	Yes
1904745846	Yes	No	No		No		
1904727019	No		No		Yes	Yes	Yes
1904654588	No		Yes	Yes	Yes	Yes	Yes
1904651253	Yes	Yes	Yes	Yes	Yes	Yes	Full Time
1904635270	Yes	No	Yes	Yes	Yes	Yes	Yes
1904630497	Yes	Yes	Yes	Yes	Yes	No	Yes
1904616314	Yes	No	No		Yes	Not sure	Yes
1904610138	Yes	Yes	Yes	Yes	Yes	Yes	Yes
1904609435	Yes	No	Yes	Yes	Yes	Yes	Yes
1904593422	Yes	No	Yes	No	Yes	Yes	Full Time
1904591477	Yes	Yes	Yes	Yes	Yes	Yes	Yes
1904587789	Yes	No	No		Yes	Yes	Full Time
1904568530	Yes	Yes	Yes	Yes	Yes	Yes	Full Time
1904496889	Yes	Yes	No		Yes	Yes	Yes
1904495859	Yes	No	Yes	Yes	Yes	Yes	Yes
1904492339	No		Yes	No	Yes	Yes	Yes
1904481393	Yes	Yes	No		Yes	Yes	Full Time
1904476433	Yes	Yes	Yes	Yes	Yes	Yes	Full Time
1904450625	Yes	No	No		Yes	Yes	Full Time
1904444254	Yes	No	No		Yes	No	Full Time
1904436112	Yes	Yes	Yes	Yes	Yes	Yes	Full Time
1904429201	Yes	No	Yes	Yes	No		
1904427063	Yes	No	No		Yes	Yes	Full Time
1904411390	Yes	No	Yes	Yes	Yes	Yes	Full Time
1904403439	Yes	No	No		Yes	Not sure	Yes
1904402787	Yes	No	No		Yes	Not	Yes

RespondentID	Q1	Q2	Q3	Q4	Q5	Q6	Q7
1904402594	Yes	Yes	Yes	Yes	Yes	Yes	Full Time
1904400706	Yes	No	Yes	No	Yes	Not sure	Yes
1904398604	Yes	Yes	Yes	Yes	Yes	Yes	Full Time
1904389461	Yes	No	No		No		
1904385068	No		No		Yes	Not sure	Not Sure
1904385064	Yes	Yes	Yes	Yes	Yes	Yes	Full Time
1904383353	Yes		Yes	Yes	Yes	Yes	Full Time
1904381548	Yes	Yes	Yes	No	No		
1904376951	Yes	Yes	Yes	No	Yes	Yes	Full Time
1904368725	Yes	No	No		Yes	Yes	Yes
1904363017	Yes	No	No		No		
1904362016	Yes	No	Yes	No	Yes	Yes	Yes
1904358384	Yes	No	Yes	Yes	Yes	Yes	Full Time
1904355510	Yes	No	Yes	Yes	Yes	Not sure	Yes
1904352897	Yes		Yes	Yes	Yes	Yes	No
1904349906	Yes	No	Yes	No	Yes	Yes	Yes
1904348819	Yes	No	No		Yes	No	Full Time
1904335036	Yes	No	Yes		Yes	Yes	Not Sure
1904331543	Yes	Yes	Yes	Yes	Yes	No	Full Time
1904324759	Yes	No	No		Yes	Yes	No
1904324505	Yes	No	Yes	Yes	Yes	Yes	Full Time
1904319409	Yes	Yes	Yes	No	Yes	Yes	Not Sure
1904319273	Yes	No	Yes	Yes	Yes	Not sure	Full Time
1904318605	Yes	No	No		No		
1904313864	No		No		No		
1904312626	Yes	No	Yes	Yes	Yes	Yes	Full Time
1904301746	Yes	No	No		Yes	Yes	Full Time
1904300770	Yes	Yes	No		Yes	Yes	Full Time
1904300755	Yes	No	No		Yes	Yes	Full Time
1904300309	Yes	Yes	Yes	Yes	Yes	Yes	Full Time
1904296454	No		Yes	Yes	Yes	Not sure	Full Time
1904295854	No		Yes	No	Yes	Yes	Full Time
1904295249	Yes	Yes	Yes	Yes	Yes	Yes	Yes
1904293027	Yes	Yes	Yes	Yes	Yes		Yes
1904291866	Yes	No	No		Yes	Yes	Yes
1904287446	Yes	No	No		Yes	Yes	Full Time
1904286575	Yes	Yes	Yes	No	Yes	Yes	Full Time
1904279408	Yes	No	Yes	Yes	Yes	No	Full Time
1904276843	Yes	Yes	Yes	Yes	Yes	Yes	Full Time
1904275067	No		No		Yes	Yes	Full Time
1904271936	No		Yes	Yes	Yes	Yes	Yes
1904270775	Yes	No	Yes	Yes	Yes	Yes	Full Time
1904265184	Yes	No	Yes	Yes	Yes	Yes	Yes
1904264039	Yes	No	No		Yes	Not	No

RespondentID	Q1	Q2	Q3	Q4	Q5	Q6	Q7
1904263430	Yes	Yes	Yes	No	Yes	Not sure	Yes
1904261816	Yes	No	Yes	Yes	Yes	Yes	Yes
1904261793	Yes	No	No		No		
1904259815	Yes	Yes	Yes	Yes	Yes	Yes	Full Time
1904259581	Yes	No	Yes	Yes	Yes	Yes	Yes
1904254602	No		Yes	Yes	Yes	Yes	Yes
1904254408	Yes	No	No		Yes	Yes	Yes
1904253463	Yes	Yes	No		Yes	Not sure	Yes
1904245655	Yes	No	Yes	Yes	Yes	Yes	Yes
1904244310	No		No		Yes	Not sure	Yes
1904244281	No		No		No		
1904243888	Yes	No	No		Yes	Not sure	Full Time
1904243530	Yes	No	Yes	Yes	Yes	Yes	Yes
1904232583	Yes	No	No		Yes	No	Yes
1904231390	Yes	No	Yes	No	No		
1904229487	Yes	No	Yes	Yes	Yes	Yes	Yes
1904229482	Yes	Yes	No		Yes	Yes	Yes
1904229184	Yes	No	Yes	Yes	Yes	Yes	Full Time
1904225855	Yes	No	Yes	No	Yes	Yes	Full Time
1904225054	Yes	No	No		Yes	Yes	
1904223257	Yes	Yes	Yes	Yes	Yes	Not sure	Full Time
1904222258	Yes	No	Yes	Yes	Yes	Yes	Yes
1904221615	Yes	No	No		Yes	Yes	Full Time
1904220797	Yes	Yes	Yes	Yes	Yes	Yes	Yes
1904220783	Yes	No	Yes	Yes	Yes	Yes	No
1904217643	No		Yes	Yes	Yes	No	Yes
1904217461	Yes	No	No		Yes	Yes	Full Time
1904217349	Yes	Yes	Yes	Yes	Yes	Yes	Full Time
1904215444	Yes	Yes	Yes	Yes	Yes	Yes	Full Time
1904214893	Yes	No	Yes	Yes	Yes	Not sure	Full Time
1904214098	Yes	Yes	Yes	No	Yes	Yes	Full Time
1904212318	Yes	Yes	Yes	Yes	Yes	Not sure	Full Time
1904211574	Yes	No	Yes	Yes	Yes	Yes	Yes
1904211268	Yes						
1904211018	No		Yes	Yes	No		
1904210879	Yes	No	Yes	No	Yes	Yes	Yes
1904208878	Yes	Yes	Yes	Yes	Yes	Not sure	Yes
1904208772	Yes	No	No		Yes	Not sure	Full Time
1904207074	No		Yes	Yes	Yes	Yes	Yes
1904206323	Yes	No	Yes	Yes	Yes	Not sure	Yes

RespondentID	Q1	Q2	Q3	Q4	Q5	Q6	Q7
1904205759	Yes	No	No		Yes	Yes	Yes
1904205672	Yes	Yes	No		Yes	Yes	Yes
1904205015	Yes	Yes	Yes	Yes	Yes	Yes	Full Time
1904204747	Yes	Yes	Yes	No	Yes	Yes	Yes
1904204616	Yes	No	Yes	Yes	Yes	Yes	Full Time
1904204218	No		No		Yes	No	Yes
1904203771	Yes	Yes	Yes	Yes	Yes	Yes	Full Time
1904203370	Yes	No	Yes	Yes	Yes	No	Full Time
1904203022	Yes	Yes	Yes	Yes	Yes	Not sure	Full Time
1904199519	No		No		Yes	Yes	No
1904162479	Yes	No	Yes	Yes	Yes	Not sure	Full Time
1904079181	Yes	No	No		Yes	Yes	Full Time
1904064875	Yes	Yes	Yes	Yes	Yes	Not sure	Not Sure
1904044615	Yes	Yes	Yes	Yes	Yes	Not sure	Yes

Survey Results Questions 8 through 13

RespondentID	Q8 YES	Q8 NO	Q9	Q10	Q11	Q12	Q13
1915658140		No		Yes	Yes	Yes	No
1915315875		No		No	No	Yes	No
1913922663	Yes		Yes	Yes	No	Yes	No
1912328089		No		No	No	Yes	No
1908872233		No		Not Sure	Yes	Yes	Yes
1908342267	Yes		Yes	Not Sure	Yes	Yes	No
1908006310	Yes		No	No	No	Yes	No
1907993946	Yes		No	No	No	Yes	No
1907695123		No		No	Yes	Yes	No
1907470517		No		Not Sure	No	Yes	No
1907467620		No		No	Yes	Yes	Yes
1907460721		No		Not Sure	No	No	No
1907442672		No		Not Sure	No	Yes	Yes
1907409596		No		Yes	No	Yes	No
1906762815	Yes		No	No	No	Yes	Yes
1906716692	Yes		Yes	Not Sure	No	Yes	No
1906711966	Yes		No	Not Sure	No	Yes	Yes
1906698583		No					
1906545507		No		No	No	Yes	No
1906448017		No		Not	No	Yes	No

RespondentID	Q8 YES	Q8 NO	Q9	Q10	Q11	Q12	Q13
1906136402		No		No	No	Yes	No
1906024593	Yes		No	No	Yes	Yes	No
1905757817	Yes		No	Yes	Yes	Yes	Yes
1905748282		No		No	No	Yes	No
1905530039	Yes		Yes	No	No	Yes	No
1905330741		No		No	No	Yes	No
1905290313	Yes		No	No	No	Yes	Yes
1905284615		No		Not Sure	No	Yes	No
1905267565	Yes		Yes	No	No	Yes	Yes
1905255052	Yes		No	No	No	Yes	No
1905250154		No		No	No	Yes	Yes
1905233300	Yes		No	Not Sure	Yes	Yes	No
1905230336		No		No	No	Yes	No
1904859006	Yes		Yes	Yes	Yes	Yes	Yes
1904856408	Yes		No	No	No	Yes	Yes
1904754688		No		No	No	Yes	No
1904745846		No		No	No	Yes	No
1904727019	Yes		Yes	Yes	No	No	Yes
1904654588		No		No	No	Yes	No
1904651253	Yes		Yes	Yes	No	Yes	Yes
1904635270		No		No	No	Yes	No
1904630497	Yes		Yes	Not Sure	Yes	Yes	Yes
1904616314	Yes		Yes	No	No	Yes	No
1904610138		No		No	No	Yes	Yes
1904609435		No		Not Sure	No	Yes	No
1904593422	Yes		Yes	Yes	Yes	Yes	Yes
1904591477	Yes		No	Yes	No	Yes	Yes
1904587789		No		No	No	Yes	Yes
1904568530		No		Not Sure	Yes	Yes	No
1904496889	Yes		Yes	Yes	Yes	Yes	Yes
1904495859		No		Not Sure	Yes	Yes	No
1904492339		No		No	No	Yes	No
1904481393		No		No	Yes	Yes	Yes
1904476433	Yes		Yes	Not Sure	Yes	Yes	Yes
1904450625		No		Not Sure	No	Yes	No
1904444254		No		Not Sure	Yes	Yes	Yes
1904436112	Yes		Yes	Yes	No	Yes	Yes
1904429201	Yes		No	No	No	Yes	No
1904427063	Yes		Yes	No	No	Yes	No
1904411390	Yes		Yes	Not Sure	No	Yes	Yes

RespondentID	Q8 YES	Q8 NO	Q9	Q10	Q11	Q12	Q13
1904403439		No		No	No	No	No
1904402787		No		No	No	No	No
1904402594		No		Not Sure	No	Yes	No
1904400706		No		Not Sure	No	No	No
1904398604	Yes		Yes	Yes	Yes	Yes	No
1904389461	Yes		No	No	No	Yes	No
1904385068		No		No	No	Yes	No
1904385064	Yes		Yes	Not Sure	Yes	Yes	Yes
1904383353	Yes		Yes	Yes	No	Yes	Yes
1904381548	Yes		Yes	Not Sure	No	Yes	No
1904376951	Yes		No	No	No	No	No
1904368725	Yes		Yes	Yes	No	Yes	Yes
1904363017		No		No	No	Yes	No
1904362016	Yes		Yes	Not Sure	Yes	Yes	No
1904358384	Yes		Yes	Not Sure	No	No	No
1904355510	Yes		Yes	No	No	Yes	Yes
1904352897		No		No	No	Yes	Yes
1904349906		No		No	No	Yes	No
1904348819	Yes		No	No	No	Yes	No
1904335036	Yes		Yes	Not Sure	No	Yes	Yes
1904331543		No		No	Yes	Yes	No
1904324759		No		No	No	Yes	No
1904324505		No		No	No	Yes	Yes
1904319409		No		No	No	Yes	No
1904319273		No		Not Sure	Yes	Yes	No
1904318605		No		No	No	No	No
1904313864		No		No	No	Yes	No
1904312626		No		Not Sure	Yes	Yes	No
1904301746		No		No	No	Yes	Yes
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APPENDIX F

Hiawatha Fire Department
Policy 440
Safety and Health
Psychological Health and Wellness Program
Date: August 1, 2012
Rev: Original

Scope:

This policy applies to all members of the Hiawatha Fire department.

Background and Purpose

The purpose of this policy is to establish a Psychological Health and Wellness Program for the Hiawatha Fire Department. NFPA 1500, Standard on Occupational health and Safety, Chapter 11 calls for fire departments of provide assistance and wellness programs to members and their families. NFPA 1500 Chapter 12 calls for fire departments to have a method to deal with potentially traumatic events. The National Fallen Firefighters Foundation's Life Safety

Initiative 13 calls for fire departments to provide access to counseling and psychological support. The Hiawatha Fire Department believes that mentally and physically healthy members are happier and have a higher quality of life. Those members will ultimate function more efficiently, effectively, and safely. HFD believes that providing psychological health and wellness programs will help maintain and retain volunteer staff. Finally, as with all risk, preparing for and preventing stress by building resiliency among members ahead of a potentially traumatic event will allow them to respond and recover faster following an event.

Policy

It is the policy of the Hiawatha Fire Department to provide access to psychological support and counseling to members and their families to support the recognition and mitigation of distress from occupational and existing stressors.

It is important to note that other policies can have an effect on stress control. Hygienic workplace factors have a role in reducing stress and assisting maintaining psychological wellness. All members should strive to maintain the FD as a workplace that is free from unnecessary stressors. Harassment and intimidation are forbidden. In addition, the Chief, Command and Company officers should strive to maintain a cohesive, inclusive organization. Individual company officer should work toward cohesiveness within their crews. Safety Policies and procedures that are followed provide members with a heightened sense of security, reducing stress. The use of Incident Command is required, and again can improve the feeling of control, thus reducing stress.

Definitions and Acronyms

City of Hiawatha: (City) Refers to the facilities, staff, elected officials, and employees of the City of Hiawatha. For purposes of this policy, it does not specifically include the Fire Department unless stated.

Command Officers: Refers to the Fire Chief, assistant chiefs and deputy chiefs.

Company Officers: Refers to lieutenants and captains.

Family: For purposes of this document, the fire department will utilize the City of Hiawatha's current policy definition of family when considering paid benefits such as the Member

Assistance Program. Where unpaid or volunteer services (such as chaplaincy services) are available, those services will be extended as needed to friends and extended families to support members needs.

Fire Department: (FD) Refers to the facilities, staff, and members of the Hiawatha Fire Department.

Member: For purposes of this policy, member refers to any volunteer, paid on call, part or full time member of the fire department. It applies to civilian volunteer, explorers, firefighters, EMS only and command officers.

Member Assistance Program: (MAP) Program contracted by the City on behalf of the FD to provide support and counseling to members.

Potentially Traumatic Event: (PTE) A potentially traumatic event is an event that is perceived and experienced as a threat to one's safety, or the stability of one's world. Other synonyms include traumatic event, atypically stressful event, high risk incidents and critical incident.

Responsibilities

Fire Chief: The Fire Chief is the overall administrator of this program who shall act as a liaison between the City and the Fire Department in all matters relating to psychological health. The fire chief shall recruit, and recommend to council for appointment, chaplains and psychological health professionals to work within this program. The Chief will appoint other individuals to receive training and act as peer supporters where necessary. The Chief will monitor all members, and specifically command staff and company officers, for signs of stress.

Safety Officer: The Fire Department Safety Officer shall be the technical coordinator for this program and shall coordinate with the Psychological Health Specialist where needed to deliver services. This includes interaction with instructors and trainers as needed to ensure that required training is delivered.

Fire Department Medical Director: Acts as the medical advisor for the program. Assist the Chief in overseeing the program by providing support and recommendations regarding the program.

Psychological Health Specialist: (PH Specialist) The Fire Chief shall recommend for appointment a qualified individual to act as PH Specialist. The PH Specialist is the clinical

director of the fire departments psychological health and wellness program. This person shall be a licensed mental health professional with a PH.D or Master's in a relevant field. Because of the unique stressors of the fire service, PH Specialist shall take steps to become familiar with the fire services. They should have specific experience in crisis intervention, general stress management, and PTSD. They will oversee the psychological health program by providing guidance to the Chief in the administration of the program, conducting annual psychological health exams and reviews, being available for consultation and counseling as needed, and assisting in referring and coordinating care where needed. They will provide oversight to the peer supporter program and provide and approve resources for training as needed.

Fire Department Chaplain: The Fire Chief shall recommend for appointment qualified individuals to act as chaplains. Chaplains will assist members, families, and victims with spiritual and mental needs. They will act as a liaison to other clergy as needed on behalf of both the fire department and members. The Chaplain may assist the Chief and Command Staff as requested, during PTEs including line of duty deaths, injuries to members, or death notifications. The chaplain may be shared with the Police Department and available to the City as needed. Because of the uniqueness stressors of the fire service, the Chief shall aid the Chaplain in taking steps to become familiar with the fire service.

Officers: Shall monitor all members, and specifically those assigned to their duty crews and incidents, for signs of distress. Officers shall act as peer supporters, and act as the first line in providing support to members. Officers shall work to identify and mitigate stressors.

Members: Shall monitor themselves and others for signs of distress and take action as needed. All members should work to build their own resiliency through training, education, and maintaining adequate levels of physical fitness.

Peer Supporters: Some members may feel uncomfortable asking an officer for assistance with issues. The Fire Chief will identify individuals, based on training, experience, communication ability, leadership, and personality to act as peer supporters. Peer supporters will support members by providing a listening ear, initial psychological first aid, identifying individuals at risk for stress, and facilitate connections to the PH Director or MAP as needed. Peer Supporters will be identified so that members can contact them as needed for support.

Training and Screening

The Fire Department shall provide training to members on psychological health as follows.

New member: During new member orientation training, each member must attend a class approved by the PH director on stress and stress management. The content of the class should include recognizing stressors and reactions to stress. Stress management techniques should be taught. Stress assessment tools shall be identified. The PH Director and Safety Officer shall insure that the training materials are current and utilize evidenced based information.

Bi-annual Training: Every other year, the Safety Officer shall schedule a review of stress and stress management techniques. This class may be offered in conjunction with EMS CEH training on a related subject or with other safety and health related programs.

On-going training: Inoculation theory states that an individual can become inoculated to a certain level of stress through exposure and training. Individuals will return to their training when faced with a stressful or challenging situation. The EMS and Fire Training officers shall strive to provide training experiences that can simulate stressful events. At least yearly an unannounced MCI or other type of high stress drill shall be held. Where possible, the PH and Medical Directors should attend these drills. Drills should be challenging enough to create stress, without causing continual distress or injury.

Psychological First Aid: Chief, Command and Company Officers, and Peer Supporters, shall complete a Psychological First Aid course. Following initial completion of the course, a renewal or review class should be held biannually.

Curbside Manner: (Note this class due to be released late 2012) Chief, Command and Company Officers, and Peer Supporters shall complete a Curbside Manner Course. They shall review that material biannually.

Annual psychological health screening: As part of the annual physical exam cycle, the mental health professional shall utilize an evidenced based evaluation tool to screen all members for signs of stress or psychological issues. The tool should have questions regarding stress, financial or family problems, alcohol and tobacco use, substance abuse, and other issues as recommended by the PH Specialist. Based on the PH Specialists review, they will schedule face to face assessments, and provide assistance or referral as needed.

Response to Potentially Traumatic Events

The FD will use the following system in responding to potentially traumatic events. Refer to the flowchart from the National Fallen Firefighters Foundation: (Refer to appendix 1)

1) Occurrence of a potentially traumatic event. Following a PTE, peer supporters will inquire of members if they require assistance, and if so, what type? While one member may find an event stressful, another may not. Peer Supporters and Officers should use their discretion in initiating this process, but should err on the side of asking the member if they need assistance. If the member does not need assistance then the peer supporter should monitor consistent with their own training.
2) Consistent with HFD policy regarding after action reviews, a hot wash or after action review shall be held in conjunction with a time out. Where possible, units and crews may remain out of service as needed for a hot wash and time out. Peer Supporters and Officers may use this opportunity to observe members for signs of distress.
3) If a member requests further assistance after the hot wash, or they appear to be having difficulty recovering, they should be referred immediately to the PH Director for complete assessment and possible referral to a specialist.
4) If a member is OK following the hot wash, but continues to report some distress 3-4 weeks following a PTE, they will be referred to the PH Director for screening utilizing the Trauma Stress Questionnaire. If their score is >6 the PH Director will provide treatment or referral to a specialist.
5) It's possible that the MAP or PH Specialist will be able to provide counseling and assistance. If the member needs care outside the qualifications and abilities of the PH director or MAP, they will be referred to a specialist with advanced training and supervised clinical experiences in specific evidenced-based treatment for PTSD, anxiety disorders and depression.

Request for assistance outside of a potentially traumatic event:

Members may wish to request assistance for a psychological health issue separate from a PTE, for example, coping with a death in the family or relationship issues. Multiple confidential pathways shall be provided for these purposes. Possible pathways include the following: Initial contact can be made through a peer supporter, fire department officer, chaplain, the PH Director,

the medical director, or directly to the MAP. In all cases, each link shall understand their limitations and the process for referral for further assistance as needed.

Alcohol and Substance Abuse:

Members should be free to seek assistance with alcohol and substance abuse issues. Outside of specific policy violations, including, but not limited to operating a department vehicle or responding to a call while under the influence, the emphasis on alcohol or substance abuse assistance is on rehabilitation and restoring a member to full function.

Certain members of HFD hold DAEC security access badges as a condition of that assignment. They are susceptible to random drug and alcohol screens while on duty, and may receive corrective action for violation of Nuclear Energy Regulations regarding alcohol and substance abuse. Loss of security access badge may result in termination based on current work assignment. This would be considered reporting to work under the influence.

Member Assistance Programs:

The Fire Chief shall recommend to the city a vendor to provide Member Assistance programs. The Member Assistance Program shall have the following components.

- Be staffed by licensed and trained mental health professionals, preferably with experience in working with public safety and health care professionals, who utilize evidence based tools.
- Be located such that access is easy, but that confidentiality can be ensured, such that members feel comfortable accessing the program.
- Have skills in interviewing, motivating, and recognizing problems.
- Have the ability to identify and assist with the following issues:
    - Alcohol and Substance Abuse.
    - Tobacco Cessation
    - Weight Loss
    - Behavior Modification
    - Anxiety and Depression
    - Family and Financial Issues
    - Cumulative Stress

Should the MAP not be able to provide these services directly, they shall have a mechanism in place to refer for further counseling.

Members shall be provided access to the MAP such that confidentiality shall be maintained. Information on accessing the program will be clearly posted in all Fire Department Facilities at all times. Members may feel free to ask the Chief, Command Staff, or Peer Supporter to assist them with contacting the MAP. The Chief, Command Officer, Company Officer, or Peer Supporter may suggest contacting the MAP. The Chief has the authority to require MAP participation as a condition of continued employment or assignment.

Confidentiality:

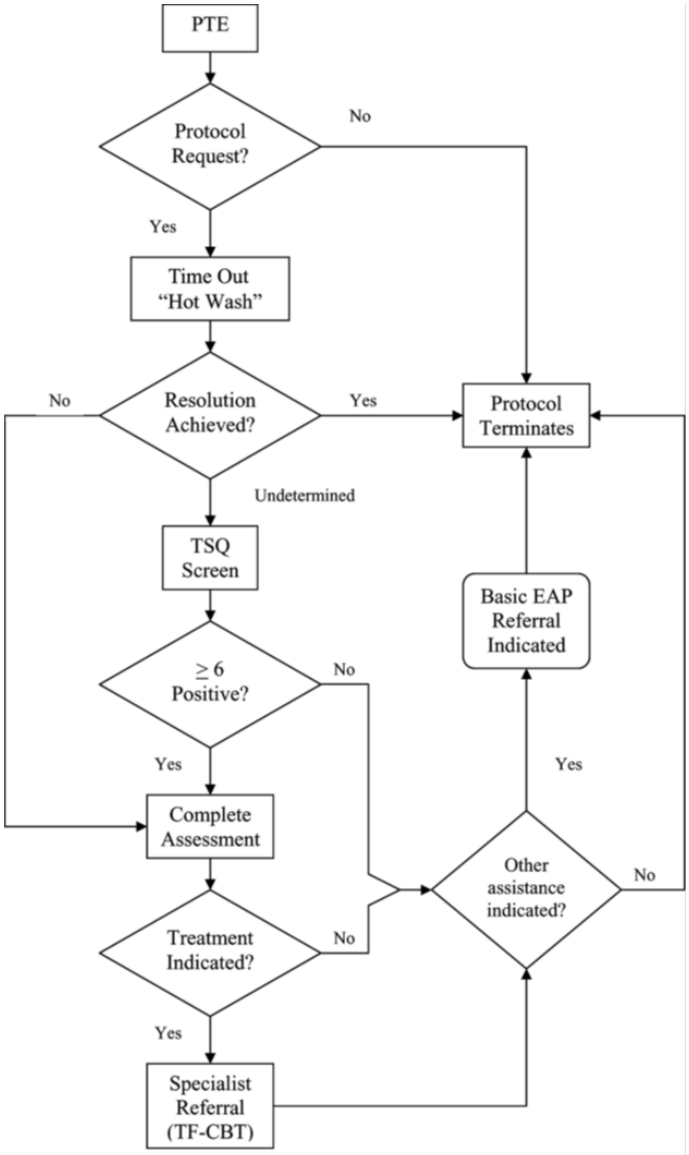
All members involved in the administration of this program shall observe strict confidentiality, consistent with existing department confidentiality policies, and the ethical and moral responsibilities of their positions. Staff and Peer Supporters must maintain confidentiality, except where seeking assistance from the PH Specialist or where there is a risk of physical harm. No psychological health records will be maintained by the Fire Department or the City.

Records:

All psychological health records will be maintained confidentially by the mental health professional that is providing services. No Psychological Health records shall be maintained by the City or Fire Department except as outlined by this policy. In the cases of referral as a condition of employment or assignment, the Chief may request evidence from a provider that a member has been participating as requested. In the cases of an issue affecting a member's ability to function, the PH Director or Medical Director will work to obtain a "Fit for Duty" release from the appropriate provider. The MAP will provide to the Chief certain information, outlined in the RFP and contract, regarding usage of the MAP in order to justify the cost of the program. This information will be void of personally identifiable information.

Policy 440, Appendix 1

Potentially Traumatic Event Flow Chart



Note: PTE = potentially traumatic event; TSQ = Trauma Screening Questionnaire; EAP = employee assistance program; TF-CBT = trauma focused-cognitive behavioral therapy.