Saving the Rescuer: Creating an Effective Critical Incident Stress Management Program

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Certification Statement

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Abstract

Critical incident stress from responding to traumatic incidents is recognized as potentially creating behavioral health challenges for emergency responders. The problem is that the Rio Rancho Fire Rescue Department (RRFRD) has not identified the elements needed in order to implement an effective critical incident stress management program which will address the long-term support of emergency response personnel.

The purpose of this research project was to identify the elements necessary to develop an effective and sustainable critical incident stress management program which will address the needs of RRFRD's emergency responders. Descriptive research methodology was used in this project to answer the following questions: a) how does critical incident stress affect the long-term behavioral health status of RRFRD first responders, as well as responders from other fire departments? b) What are the elements of a critical incident stress management system that are not considered effective in addressing the long-term emotional support of first responders? c) What elements of a critical incident stress management system are considered to be effective in addressing the long-term emotional support of first responders? and d) How do fire departments and other first response agencies provide and deliver critical incident stress management services to their personnel?

A review of contemporary literature, as well as original research incorporating surveys, interviews, and other correspondence were employed to investigate how to identify the elements of a successful behavioral health program for RRFRD firefighters. It was determined that developing a system based on a strong foundation of after action reviews, a peer support network, an employee assistance program, the department’s chaplain program, and professional behavioral health providers would create a program which would be sustainable and effective.

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Saving the Rescuer: Creating an Effective Critical Incident Stress Management Program

Introduction

Firefighters, police officers, and emergency medical technicians (EMTs) are on the front lines to witness tragic events. First responders are subjected to first-hand encounters with the pain, suffering, and sometimes the death of others as they perform their assigned duties of mitigating emergencies. The mental images of human suffering and seeing others on the worst day of their lives can create emotional stress among those tasked with helping those in need. Critical incident stress from responding to fire and medical and traumatic incidents is recognized as potentially creating behavioral health challenges for emergency responders. The problem is that the Rio Rancho Fire Rescue Department (RRFRD) has not identified the elements needed to implement an effective critical incident stress management program which will address the long-term support of emergency response personnel.

The purpose of this research project is to identify the elements necessary to develop an effective and sustainable critical incident stress management program which will address the needs of RRFRD's emergency responders. Descriptive research methodology will be used in this project to answer the following questions: a) how does critical incident stress affect the long-term behavioral health status of RRFRD first responders, as well as responders from other fire departments? b) What are the elements of a critical incident stress management system that are not considered effective in addressing the long-term emotional support of first responders? c) What elements of a critical incident stress management system are considered to be effective in addressing the long-term emotional support of first responders? and d) How do fire departments and other first response agencies provide and deliver critical incident stress management services to their personnel?

Background and Significance

Rio Rancho Fire Rescue Department (RRFRD) serves the citizens, businesses and visitors to the City of Rio Rancho (CRR), New Mexico. Rio Rancho's borders spread across 103 square miles of high desert land, located northwest of the larger metropolitan area of Albuquerque. A population estimate of the CRR in 2014 was reported as just over 93,000 residents. The city was incorporated in 1983 and was primarily a residential suburb of Albuquerque. Recently, however, the CRR has experienced significant growth in commercial and industrial occupancies. In 2012, two full-service hospitals were constructed within the borders of the city. There is also a large Intel computer chip manufacturing plant located in Rio Rancho. The residential make-up of the CRR is comprised of a significant population of older retirees, as well as many young families. Safe streets and a good school system were reported as the reason that Rio Rancho was named one of the 10 best towns to raise a family (Nayyar, 2013).

RRFRD provides response to structural and wild land fires, emergency medical services (EMS) calls, technical rescue, hazardous materials (HazMat) incidents, and general service calls out of six staffed stations. The department employs 104 personnel who are assigned to operations, administration, fire prevention, or emergency management. All personnel are cross-trained for firefighting, technical rescue, and EMS response. The department provides first response and transport of the sick and injured through five paramedic-staffed rescue ambulances (RA). The operations division is comprised of three battalions, or shifts, which are on-duty for 48 hour shifts, then off-duty for 96 hours. Firefighters provide staffing for four engine companies, five RA units, and two 75-foot quint-aerials. A battalion chief provides management and incident command for each shift and each station is staffed with a captain who serves as a front line supervisor. The administrative division consists of the Fire Chief, a deputy chief, a battalion

chief of training and logistics, a battalion chief of EMS, an EMS captain, a logistics captain, an administrative paramedic, and an administrative assistant. The administrative paramedic provides support for the department's community outreach program as well as the occupational medicine program for firefighters. The fire prevention division is comprised of a fire marshal and three fire inspector/investigators. The emergency management department employs an emergency manager and assistant emergency manager. A physician under contract with the city provides medical direction and occupational medical exams for firefighters.

Although considered a relatively safe community, the CRR is an emerging suburb of Albuquerque and is beginning to suffer from many of the issues facing larger communities. An increase in crime activity, more traffic congestion, as well as an aging population contributes to the 8,000-plus calls for service experienced by RRFRD in 2013. There were 18 incidents involving gunshot or stab wounds, 85 cardiac arrest responses, 43 structure fires, and 604 calls for traumatic injuries in 2013. Additionally, RRFRD firefighters responded to and provided medical care to 404 calls for suicidal patients, and for 1,016 pediatric medical and trauma incidents. Some of these scenes were considered horrific or significantly emotional by some RRFRD responders, which contributed to their cumulative incident stress levels. The experiences witnessed by firefighters and other first responders are thought to add to the stresses that most other people encounter every day. Family, finances, and home life are said to further the strain on the emotional stability of firefighters.

Firefighters have been traditionally known to be tough to handle the grime and gore of their profession. There is a certain amount of machismo among these first responders due to their perceived ability to carry out their daily tasks without the emotional toll it would take on the general population. Many firefighters learn how to suppress their emotions after witnessing

significant incidents (Antonellis, Meshad, & Stack, 2006). Post-traumatic stress disorder (PTSD) became more common in 1980 and was identified as a syndrome of emotional and behavioral disturbances that may follow exposure to a traumatic event or incident. At times, those suffering from PTSD may experience intense fear, helplessness, or even horror. Soldiers who have experienced combat are often associated with the classic PTSD symptoms (Miller, 2011); however, firefighters, police officers, EMS personnel and other first responders are now included in the at-risk population for PTSD. Physical symptoms of PTSD can include restlessness, fatigue, insomnia, nausea and loss of appetite; while emotional symptoms can manifest as anxiety, intense grief, detachment from family and society, guilt, agitation and even depression. Symptoms that affect a person's cognitive abilities may include intrusive images invading their thoughts, poor concentration, disbelief and despair (DeFraia, 2013).

According to the American Psychiatric Association (APA), PTSD affects roughly seven to nine percent of the general population; however, some studies have indicated that the firefighting community suffers PTSD rates as high as 24 percent. Symptoms of behavioral disorders have also been reported in the retired firefighter population as well. Although the focus on providing recognition and treatment for PTSD and other behavioral issues is becoming an issue on the forefront of the American fire services, the U.S. Fire Administration (USFA), the National Fire Protection Association (NFPA), and the International Association of Fire Chiefs (IAFC) are not currently tracking how many firefighters are actually diagnosed with PTSD or other disorders (Antonellis, Meshad, & Stack, 2006). Additionally, tracking of firefighter suicides has been difficult due to the fact that the USFA only maintains records of line of duty deaths (LODD), which refers to the firefighter being involved in the operations of an incident, responding to or returning from an incident, or while performing assigned duties. The National

Fallen Firefighters Foundation (NFFF) has historically excluded firefighter deaths due to drug or alcohol abuse, or victims acting in a grossly negligent manner (Carey, 2014). Since most suicides occur during off-duty hours, they have generally not been considered a LODD. It is important to note that since the reasons for firefighter suicides are not typically reported, it is unknown if incident stress could have contributed to these occurrences.

Over the past several years, six firefighters from RRFRD have initiated conversations with the author of this research project requesting assistance with counseling services for the stress they were experiencing due to their response to critical emergency incidents. RRFRD has several options available to provide responders the ability to talk about their experiences after working on significant emergency incidents. The New Mexico State Department of Health/Emergency Medical Services Bureau offers peer counselors who have received basic training in Critical Incident Stress Debriefing (CISD) and will respond to the department after a request has been placed with the agency. The counselors conduct facilitated discussions with the first responders in an effort to allow them the opportunity to voice their emotions over the call. In addition, RRFRD has two chaplains who have the ability to meet with firefighters, either one-on-one or in groups to discuss their emotions after particularly traumatic incidents. One of the chaplains is a local priest at a Rio Rancho Catholic parish, while the other is a chaplain at a non-denominational Christian church in the city. Lastly, the CRR Human Resources Department has contracted with a behavioral health counseling agency in Albuquerque to offer all employees services through the employee assistance program (EAP). Currently, the city will fund up to six sessions with a counselor, while the chaplain and state CISD program are free and potentially unlimited to the firefighters. After the RRFRD firefighters sought out these services, most stated that their expectations of the resolution of their issues were not completely resolved. These

unmet needs left the RRFRD first responders at risk for developing further emotional or behavioral issues if their incident stress was not properly addressed.

Firefighters and other first responders are being increasingly tasked with additional responsibilities to meet the demands of their communities. Fire suppression, technical rescue, fire prevention, public education, emergency management, and EMS are often the assigned responsibilities from the communities they serve. The recent additions of mobile integrated healthcare or community paramedic programs are further stretching fire department resources. These additional challenges, along with more complex incidents and little down time have proven to be stressful for firefighters (Pennington, n.d.). When these additional tasks and complex incidents are combined with juggling the day-to-day challenges of raising a family, balancing a household budget, and poor sleep and fitness patterns, firefighters are at risk for experiencing behavioral health issues (Fontenot, 2014). Responders are required to make decisions very quickly when dealing with emergency situations. Dealing with these critical situations can create psychological, social, and physical effects on the emotional well-being of first responders (Maxon, 2013). Emergency personnel who are witnesses to disasters and other incidents and events can be affected by a stressful impact, which can cause strong emotional reactions and a decreased ability to cope with everyday stresses. In addition, emergency workers can also experience counter-transference, which causes them to identify themselves with the victims they are helping. All of these emotional impacts can cause the rescuer to undergo compassion fatigue (Jones & Majied, 2009).

Stress is a normal reaction to an abnormal situation and it is designed to help people cope with situations that are potentially dangerous or threatening. The stress reaction prepares the mind and body to respond to the threat so that the issue can be mitigated. However, when stress

occurs over a long period of time, the human body generally cannot withstand the psychological changes that occur. Firefighters who experience chronic stress are at risk for damaging their physical and emotional health, as well as encountering the possibility of decreased job performance and increased strain on their family (Ballard, 2014). The increased stress that firefighters are now facing can cause even further damage. There has been recent attention on firefighters who are commit suicide. Although there is no direct correlation to incident stress and the suicides, it is theorized that these work-related stressors are contributors to these acts of self-destruction. In 2009 the Chicago Fire Department had six firefighters die from suicide, while four committed suicide in just a seven-month period in the Phoenix Fire Department. Eight firefighters from Philadelphia died from suicide in the past decade (Pignataro, 2013).

Firefighters have, historically, presented themselves as being tough and able to handle the physical and emotional stress associated with emergency response. In the typically male-dominated profession, it has been expected that the firefighters “suck it up” and put on a brave face for the community they serve (Pennington, n.d.). First responders are expected to be emotionally and mentally strong to the public, and especially to their fellow firefighters. After difficult incidents, they are expected to dismiss the set of emotions and graphic images that have been stored in their minds; hence, they tend to put “on a brave face around fellow responders” (Tobia, 2013, p. 5). Another issue that could potentially create emotional stress for emergency response personnel is the guilt they experience when they are unable to help the victims or patients involved in the incident. Firefighters and other first responders are expected to bring order to an otherwise chaotic situation. Although they attempt to save the lives they have sworn to protect, sometimes their best is not good enough (Meehan, 2013).

The NFFF, along with the USFA, released the 16 Firefighter Life Safety Initiatives which outlines recommendations in an effort to drastically reduce firefighter injuries and fatalities. Life Safety Initiative #13 states that "firefighters and their families must have access to counseling and psychological support" (Eisner, 2013, p. 14). Although RRFRD offers several resources to firefighters who may request assistance in dealing with critical incident stress or other behavioral health issues, these tend to be limited and do not offer a progressive approach to addressing these problems. The goal of this research project is to identify the elements necessary to develop and implement a sustainable and effective critical incident stress management program which will provide long-term behavioral health support for firefighters. This project will allow the author to utilize knowledge and skills acquired through the Executive Leadership (EL) curriculum, which is the capstone class to the National Fire Academy's (NFA) Executive Fire Officer Program (EFOP). The EL course materials define an adaptive challenge as one that "may require people to alter their assumptions, use different methods than they normally use, and develop new tools and behaviors" (U.S. Fire Administration [USFA], 2013, p. SM 2-5). Additionally, this project also addresses the U.S. Fire Administration's (USFA) goal to:

> "Reduce risk at the local level through prevention and mitigation. Every disaster or emergency is local and personal, and being prepared is both an individual and collective responsibility. Prevention has to be a part of the public consciousness: automatically applied, regularly practiced, and always respected. The USFA intends to be a national model and advocate for local, state and national activities that develop, promote, enforce, and reward awareness, preparedness, and prevention" (U.S. Fire Administration [USFA], 2010, p. 14).

The USFA's first goal also focuses on reducing the line of duty deaths suffered by firefighters in the United States through preparedness, training and safety practices. The development of an effective program to address the long-term behavioral health needs of firefighters can reduce the risk of

firefighters suffering through PTSD or other mental health issues, which can effectively decrease the likelihood of suicides or early retirement due to unmet healthcare needs.

Literature Review

Firefighters, EMTs, police officers and other first responders are tasked with the mitigation and stabilization of many types of emergency incidents. In a single duty shift, they may be on the front lines to witness pain, suffering, and even death as they answer the calls of those in need. At times, first responders see themselves or their family members in the eyes of their victims and patients, and this transference can create a significant amount of incident stress among these public servants. Chronic exposure to traumatic events can have a cumulative effect on the behavioral and mental health of firefighters, police officers, and others who are responsible for responding to emergency incidents.

Stress can have serious physical and emotional implications for the first responder; however, among firefighters, these injuries to their bodies and their minds have traditionally been accepted as a normal side effect of their profession (Swanson, n.d.). Firefighters and other emergency responders are being overly tasked to accomplish a growing list of responsibilities. Tight budgets, aging apparatus and facilities, fewer people to respond, and working with antiquated technologies has pushed fire departments to their maximum capacity. After the acts of terrorism caused the collapse of the World Trade Center towers in New York City on September 11, 2001, there was an increase in the awareness in the minds of many firefighters that they put themselves in harm's way to save others. There was an outpouring of empathy for the physical and psychological sacrifices that firefighters make daily (Allen, 2011).

The additional stress placed on responders has increased the risk of firefighters suffering from PTSD. In a 2007 survey of responders in a North Carolina fire department, 20% of the staff had self-reported that they were victims of PTSD (Wright, n.d.). In another survey, a group of

Executive Fire Officer students were asked if their department had ever experienced an incident that would be considered critical. Over 95% indicated that their personnel were at-risk to some degree (Groody, n.d.). It has also been stated that all personnel who respond to disasters and large emergency incidents experience some level of stress (Jones & Majied, 2009). In a 2013 survey of nearly 400 firefighters in New Mexico, over 60% indicated that they have experienced anxiety while responding to emergency incidents, and almost 65% stated that they had suffered from acute psychological reactions at some point during their career (Maxon, 2013).

Throughout the history of the American fire services, departments have been proactive in preparing their personnel to handle the physical demands of the job, but the mental health aspect has received relatively less attention (Thomas, 2009). Firefighters appear to be an at-risk population for suffering from PTSD or other emotional injuries due to the nature of their work. Their long-term behavioral health can be negatively impacted if their symptoms are not recognized and addressed.

Firefighters and other first responders are often witness to horrific incidents and the common emotional reaction can sometimes be fear, anxiety, sadness, or even anger. These feelings are considered normal and are generally not diagnosable as PTSD or even acute stress disorder (ASD). Symptoms of PTSD can include unexpected memories of the incident reoccurring unexpectedly over time. Sometimes these re-experiences are called flashbacks; however, they are associated with strong emotions and can be so vivid that the responder feels that they are back at the original scene. These flashbacks can happen in the days, months, or even years after the event. People who are suffering from PTSD also tend to find the means to avoid any type of reminder of the incident. Conversations or activities similar to those that were involved in the incident can be a trigger to these strong emotional ties. Additionally, associating

with people who were there, such as co-workers, may also cause the flashback. Therefore, firefighters may call off sick if they suspect that their duty shift will create memories of the traumatic event. PTSD tends to occur after at least a month post-incident, while ASD will have similar symptoms but is more likely to occur within several days, weeks, or months after the incident (Antonellis et al., 2006). The avoidance of reminders can also create a sense of detachment for the responder. They may become emotionally numb to any stimuli and lose interest in activities. Workers that suffer from PTSD or ASD can appear distracted to their supervisors and experience a drop in their performance level (DeFraia, 2013). PTSD or other disorders can cause a firefighter to feel like they do not fit in, that nobody understands them, or they may experience a period when they don't have any emotion at all. Firefighters may also experience survivor guilt which can inhibit the enjoyment of their lives, or they may even become self-destructive (Pennington, n.d.). In addition, the direct costs associated with these disorders can include the overuse of sick time, back-fill overtime pay, or medical and counseling expenses. The indirect costs may take the form of a loss in job satisfaction, the decrease in the department's esprit de corps, or reduced performance in job duties (Billings, n.d.).

In a disaster situation, responders may work long hours in austere conditions. Their efforts may be fueled by adrenaline and desire to have a positive effect on the victims of the event. During these incidents, rescue workers may work to the point of exhaustion and eventually be overcome with emotions, such as frustration and disappointment. Also, being physically exposed to the deaths of others or seeing numerous dead bodies can increase the stress for disaster workers. This can especially affect those who may think that the fate of themselves or their families could have been similar to that of the victims. This can lead to a psychological disability for these responders (Miller, 2011).

Secondary victims of firefighter stress can be their family members. When first responders unknowingly take their chronic stress issue home with them after a tough shift, their mood swings, short tempers, depression, and disinterest can create strained relationships in the family (Billings, n.d.). The persona that firefighters may exhibit at the fire station may be completely different than the one that their family witnesses at home. They may be happy and content while at work, but due to the demands and stresses of the job, family members may see a grumpy, exhausted and irritable firefighter at home (Mercer, 2014). Additionally, the pressure that firefighters place on their families due to lost time at home, missed holidays, and the frequent hiding of true emotions from family members, can create tension in the home. Divorce can be a result of these stresses, and the experience of going through a divorce can create additional stresses on a firefighter while on duty (Padgett, 2013).

Firefighters and other first responders who may be suffering from PTSD or other emotional issues can submerge themselves in addictive behaviors, depression, or even consider suicide. These feelings and behaviors can be accentuated after the responder retires and they lose their sense of identity and purpose (Dill, 2014). Chronic exposure to traumatic scenes can take an emotional toll on firefighters. One call, which may not even be a significant incident, can prove to be the proverbial “straw that broke the camel’s back” when it comes to behavioral health of the responder. A single call can be the one that “unleashes 30 incidents worth of emotional fall out,” (Wilmoth, 2013, p. 6). In a survey of Executive Fire Officer students, it was determined that personnel from fire departments across the country indicated that they had experienced symptoms of emotional injuries due to their emergency incident response. Some of the symptoms they described were confusion, nightmares, insomnia, fear, guilt, depression, sadness, stress, tension, as well as the use of alcohol and other means of self-medication (Groody, n.d.). It

is becoming increasingly important that fire department leadership recognize these signs and symptoms of emotional stresses among their personnel and assure that they are pointed to the proper resources.

Fire department company officers are in a unique position to identify issues with their crew members and make sure that they seek assistance from the department's programs. In most agencies, however, these lieutenants and captains are not given the proper tools, such as training, to recognize and properly address these problems. Too often departments are focusing a great deal of energy on the physical aspect of training and no efforts are put into preparing the firefighter's emotional condition. "Keeping a firefighter from forcing the wrong door or throwing a ladder into the wires is infinitely easier than having a one-on-one conversation with them about not committing suicide," (Tobia, 2013, p. 5). Identifying firefighters who may be suffering from emotional stress is not an easy task. Every firefighter reacts differently to stress caused by incident response. Most develop their own coping skills to deal with the effects of incident stress. Even when an entire station crew experiences the same incident, each member of that team may have a different reaction to it. Individual firefighters each bring their own experiences, knowledge, background, and training to help them cope with the emotional impact of emergency response (Gayk, 211). The emotional toll of witnessing traumatic incidents and emotional events can ultimately harm the wellbeing of firefighters and first responders. It is therefore critical for departments to offer crisis intervention programs to help workers cope (Telis, 2014). It is incumbent on agencies to develop programs that effectively address these emotional challenges and discard programs and procedures that are considered ineffective.

Reviewing a critical emergency incident on the apparatus tailboard and formal incident debriefings have been the gold standard of defusing incident stress among first responders for

several decades. It was thought that these formal group discussions were the most effective method for reducing the anxiety and stress experienced by first responders. However, there is growing evidence that some of these programs are not only ineffective, but they could potentially be harmful in the long-term behavioral health of emergency responders. Department leadership must find programs that are aimed at the mental and behavioral stability of their personnel, and discontinue programs and procedures that are unproductive in addressing the emotional support of firefighters.

Critical incident stress debriefing (CISD) is a formally structured group intervention that is designed to encourage the emotional processing of traumatic incidents through an open forum and the stated normalization of a responder's reaction. It may also be the goal of a CISD facilitator to prepare the responder for the next critical emergency incident. Typically, a CISD session is led by a peer facilitator and guided by a clinician. The roles of the peer and clinical personnel may vary from agency to agency. The peer leader usually will have a minimum level of training in the process and it is assumed that they have experiences that are similar to those being debriefed. Normally, these sessions should take place in 24 to 72 hours post-incident. Each session can last up to several hours, depending on circumstances and the openness of the participants (Miller, 2011). CISD has always been considered a component to the longer-term goal of critical incident stress management (CISM). In an effort to mitigate the stress and potential behavioral issues associated with emergency response, CISM has been the clinical standard utilized as a stand-alone practice by public safety entities as a means of providing crisis intervention for their personnel. CISM has been used as a cost-effective method to mitigate the potential of PTSD among emergency responders; however, there has been a growing theory that these programs are ineffective, and potentially harmful to first responders (Chumley, 2012). The

one-size-fits-all approach to CISD/CISM in not, necessarily, considered to be working effectively for the large majority of firefighters. Additionally, these programs do not seem to be successfully identifying underlying problems facing firefighters (Kelly, 2014).

Medical and mental health providers are taught the phrase “primum non noccere,” or “first, do no harm,” early on in their education. New evidence has shown that there are some psychological treatments, including CISD programs, which may create harm among those who were targeted for help. The APA’s code of ethics states that all clinicians must avoid procedures that place clients at risk of deterioration. This could include worsening of or new symptoms, excessive reliance on therapy, or even physical harm. In a meta-analysis of randomized controlled trials, it was reported that CISD received a Level I rating, which means that the therapy is probably harmful for some individuals and adds risk for PTSD symptoms (Lilienfeld, 2007). It has also been noted that a study for the Federal Emergency Management Agency (FEMA) concluded that CISD sessions were ineffective in addressing and preventing PTSD. The World Health Organization (WHO) agreed with the study’s findings and added that single-session psychological support sessions can push a responder to share personal and private information that they would not normally share with their peers (Pignataro, 2013). The NFPA has also shown support for a change to how critical incident stress is handled by fire departments. In 2011, the NFPA 1500 revision committee removed language in the professional standard for fire department occupational health programs that specified the use of CISD or CISM as a stand-alone standard practice. Instead, CISD and CISM should be considered a singlestep in a multi-step process of managing the overall health and wellness of firefighters (Holland, 2012). Many other agencies are following suit in dropping the standard use of CISD and CISM programs for managing stress. The National Institute of Mental Health, the U.S.

Department of Health and Human Services, the Department of Defense, the Department of Veterans Affairs, the Department of Justice, and the American Red Cross have all reported that they no long support the use of or recommendation of CISM as an early intervention program (Chumley, 2012).

There has recently been a change in the focus on CISD programs due to the contention that these traditional programs may inhibit a firefighter's recovery from a critical incident by exposing them to additional behavioral stress during an emotionally-charged debriefing (Bourgeois, 2013). Another indication that CISD programs has fallen into disfavor with first responder agencies is the fact that the number of debriefing sessions have recently decreased. This comes at a time when EMS incidents and the tasks associated with providing care to patients is far more violent and graphic that it has been in the past. This may be due to better coping mechanisms among individual providers, or that there is a perceived safety in numbers. Donning the uniform or firefighter bunker gear may provide an emotional suit of armor in fighting incident stress (Meehan, 2013). It is also possible that the decrease in the use of formal CISD debriefings may have been caused by the fear of being ridiculed or becoming embarrassed over admitting to an emotional injury during a group discussion. There are some responders that feel that CISD sessions tend to lack confidentiality and can potentially harm their pride (Swanson, n.d.). An unknowing company officer may also feed into the ineffectiveness of CISD sessions by playing off the seriousness of the incident as no big deal, or the "man-up" mentality of the fire house culture. This inadvertent misdirection of emotional energy can create an environment where long-lasting behavioral injuries are possible (Gayk, 211).

Another challenge with CISD programs that has been identified is that most programs do not have the capability to prescreen workers for their risk for emotional disorders due to

exposure to trauma. Hence, when a responder is requested to attend a post-incident debriefing, the department may not be aware that the employee is at a high risk of increased stress due to the discussion about the incident. Individual first responders' responses to stressful situations can range from resistant, to resilient, to those who may require recovery through specialized care. Although the latter group is a relatively small 14% of the work force, these employees are at risk for developing ASD or PTSD symptoms (DeFraia, 2013). The current model for CISD and CISM being utilized in many departments may be currently providing support and information to first responders that are outdated, outmoded, or using discredited theories and procedures. The analogy that is being applied to illustrate this point is the use of medical devices and treatment modalities employed by EMTs and paramedics in the treatment of their patients. The use of evidence-based medicine to prove that the use of military anti-shock trousers, or bystanders delivering breaths with cardio-pulmonary-resuscitation are considered ineffective is very similar to study results that have shown that CISD is no longer effective (National Fallen Firefighters Foundation [NFFF], 2007). These studies have provided information that will help department leadership in finding programs and procedures that are considered effective in assisting with the long term behavioral health of firefighters.

There are many types of CISD and CISM programs being utilized by first responder agencies. Some of these programs stem from military models, while others use information from research studies and past-practice procedures with firefighters and others. One of the tenets of a successful program is that responders must be allowed to speak freely about the incident and their feelings about their involvement in the critical event. It has been shown that different people react differently to various traumatic situations (Thomas, 2009). Immediately following exposure to a traumatic event, those who were witness to the pain and suffering may have

difficulty in expressing their feelings to a therapist, or anyone else leading a group discussion. They may feel that talking about the misfortune of others could possibly make it more real in their minds (Miller, 2011). There are many options available for the treatment of mental stress issues that firefighters are experiencing. “Behavioral health issues are treatable and curable,” (Mercer, 2014). The individual’s response to behavioral health issues is personal and most responders that are suffering from post-incident stress tend to choose the program that will be beneficial to them (Matthews, 2011). The bottom line is that anyone who may be experiencing the symptoms of ASD or PTSD must realize that it is OK to ask for help (Meehan, 2013). In addition to the traditional post-incident CISD, there are a host of programs that have been shown to be effective in addressing the mental health issues of responders. Among these programs that have shown promise are psychological first aid (PFA), after action review (AAR), and the peer support team (PST) approach.

PFA was developed as a crisis intervention program to help firefighters and other responders deal with the stress associated with emergency response in order to prevent the possibility of developing PTSD. The 2008 National Response Framework recommends the use of PFA for first responders. The foundation of PFA is to promote a sense of safety, calming, and hope, among other principles. PFA sessions are led by a facilitator trained in the process and can come from professional mental health providers, the lay community, from a group of peers, or from clergy. These providers can be embedded into an organization’s infrastructure to assist with issues as they arise (Chumley, 2012). The objectives of PFA programs are to establish a human connection in a non-intrusive and compassionate manner and to connect those in need with their social support network (National Child Traumatic Stress Network, National Center for PTSD, n.d.). PFA programs have been shown to help first responders deal with stress related to their

duty, and these are becoming more prominent as a method to prevent further psychological issues (Maxon, 2013). Additionally, PFA is considered more effective than traditional CISD programs. One of the main reasons for this contention is that PFA is performed by competent mental health professionals and addresses any acute concerns that are brought forward during the session. Although PFA is not considered treatment for these issues, it is thought that the presence of a trained provider can help to identify potential problems with the behavioral health of responders (Pignataro, 2013).

Another method that is available for fire departments to utilize for defusing the behavioral aftermath of a potentially traumatic incident is AAR. These informal debriefing sessions were derived from a military model in order to improve the capacity for the organization to better learn from their actions. Additionally, AARs support the development of process and skill (Gist, Taylor, & Raak, 2011). The NFFF proposes the use of AAR after each and every response by fire department personnel. These informal gatherings on the apparatus' tailboard or around the kitchen table at the station give the crews an opportunity to discuss the positives and negatives of every emergency incident. These AAR sessions could also be employed to debrief training exercises and other tasks associated with daily department duties. The foundation for AARs involves the firefighters asking themselves a series of five questions: What was our mission? What went well? What could have gone better? What might we have done differently? And, who needs to know? (Eisner, 2013). It has been suggested that AARs should become as routine as cleaning the equipment and restocking the rig after every call (Nicol, 2013). There are detractors to the AAR model who state that to perform these reviews after each incident and training exercise will be difficult to accomplish, especially in smaller, resource-challenged fire departments (Pennington, n.d.). One of the advantages to AARs over PFA programs is that

AARs can be facilitated by a trained peer provider versus mental health professionals necessary for PFA debriefings.

PST involves the use of firefighters and others within the department to talk to their coworkers who may have experienced stress due to exposure to a traumatic incident. This one-on-one approach allows the firefighter in need to express their feelings and decompress after an event (Telis, 2014). Addressing the incident stress issues with disaster workers, peer support programs have shown to be effective in reducing the stress experienced by the workers while improving health outcomes. Improved work performance and emotional recovery after a disaster have also been reported as benefits to these programs (Jones & Majied, 2009). Police departments have also seen success with peer support programs due to the reluctance of officers to cross the "thin blue line to talk about their experiences with someone not associated with law enforcement," (Chumley, 2012, p. 31). The PST concept is also believed to be beneficial to firefighters, although, due to these programs being fairly new to the American fire services, there is little data to support the efficacy in preventing chronic behavioral health issues among firefighters. In departments where peer support programs have been established, they appear to prove effective as a proactive approach, especially after a large incident. In the North Carolina study on peer support program effectiveness, nearly 80% of respondents in a survey indicated that their department's program helped their situation. Of the respondents, 62% had utilized the program to refer employees for additional care through another program, while 25% had used the PST as a means to be proactive after a significant emergency incident (Wright, n.d.).

The strength of a peer support program is designed so that the firefighters are able to take care of their own. Peer-to-peer support and motivating each other as a team is one of the distinguishing factors of belonging to a fire department (Wilmoth, 2013). One factor that was

identified as being important to the development of a peer support program is to recruit members of the department who are well respected and trustworthy. Peer counselors must also be discreet as many of the issues they deal with are confidential in nature. Firefighters must be able to turn to a peer team member when they are in need of defusing potential behavioral health issues (Bourgeois, 2013). Successful peer support programs have been utilized in several large metropolitan fire departments. Chicago and New York City are both using versions of programs which involve peer counselors. Each department is also employing internal training for counselors, which allows for a cost-effective method of preparing their personnel while creating a system of regular educational updates (Swanson, n.d.). Whether departments deploy CISM resources through PFA, AAR or PST, there must be support from all ranks of the department as well as an effective implementation plan to assure the program's success. Departments must also realize that taking care of the behavioral health needs of their personnel is not a single-tiered approach.

Fire service leadership must recognize the importance of providing behavioral health support for their personnel. "Chief officers must take the lead in ensuring their department members are truly prepared to perform their jobs both physically and mentally," (Padgett, 2013, p. 3). The National Volunteer Fire Council has recognized the need for behavioral health programs and has introduced the Share the Load program in an effort to break the stigma of these issues among firefighters. The program intends to open the dialogue within a department in order to prevent tragedies associated with behavioral health ("Behavioral health program," 2014). In a survey of Connecticut firefighters, results found that support from the department administration was very important to the success of a program. Of the respondents, over 85% had indicated that support from the leadership was essential. This buy-in approach by the executive staff was

determined to be important to help remove the stigma of stressed firefighters needing help. Nearly 60% stated that they felt EAP services were essential. Almost 94% felt that access to chaplains was important or essential, while 98% had indicated that a PST program would be important or essential to the crews. Everyone who answered the survey stated that they felt access to mental health practitioners was important or essential (Billings, n.d.).

Traditionally, most fire departments provide services to their personnel that address behavioral health challenges that firefighters are experiencing. Chaplain services and EAP resources are often the most common programs available. In developing effective CISM programs, fire department leadership should focus on developing strong relationships with the providers who will be serving the front-line staff. A fire department chaplain will not be successful if they are not properly vetted for the tasks at hand. Just as every person does not have the desire or capabilities to become a firefighter, not all clergy have the desire or capability to become a fire chaplain. Chaplains who serve firefighters must be dedicated to helping firefighters and their families in times of crisis and with spiritual needs. They need to be available at a moment's notice and provide support when a firefighter becomes injured or dies in the line of duty. Lastly, fire chaplains must also gain the respect of firefighters. They must show commitment, dedication and true concern for firefighters and their families (Federation of Fire Chaplains, 2002). It has been shown that most individuals tend to turn to prayer or access their spiritual beliefs in the wake of a disaster. This can make the use of trained department chaplains a valuable resource. Due to their background, they are generally seen as trusted individuals (Chumley, 2012). Employers who provide their personnel with EAP services should look at the level of care being delivered to firefighters dealing with incident stress. Individual firefighters may have differing levels of stress response and may require varying levels of care. However,

many employers expect that EAP providers have the ability to deal with a large variety of other issues as well. Firefighters may also benefit from family counseling, everyday work stress issues, and other behavioral health needs (DeFraia, 2013).

Departments that implement the PST approach to CISM have experienced that peer counselors tend to understand their fellow firefighters and what they are experiencing. First responders tend to be more comfortable with those who work side-by-side with them (Thomas, 2009). Firefighters in Hanover Park, IL, described peer support programs as one member of the department helping another with emotional and spiritual issues. They also indicated that it was important that peer counselors have the ability to listen, be supportive, be available after tough calls, and uphold confidentiality (Swanson, n.d.). First responders tend to see each other as members of their workplace family. From early on in their training, firefighters are taught to take care of themselves first, and then take care of each other. Generally, peer support will take place in an informal setting among the crews (Jones & Majied, 2009). Another method that was developed for addressing the short-term needs of responder stress is the Trauma First Aid model. The goal of the program is to help reduce the symptoms of acute stress and stabilize the body's nervous system during urgent situations. By assisting with the short-term needs of responders, it is the target of the program's designers to return responders to their normal function after experiencing the survival instinct during the incident ("What is trauma," n.d.).

Firefighters who have personally witnessed traumatic events, especially over the course of many years during their careers, may need more than having the ability of talking to a chaplain, counselor with EAP services, or a member of a PST; they may need treatment from mental health professionals who specialize in diagnosing and treating PTSD or other trauma-related disorders. These providers are often referred to as "traumatologists." Many

traumatologists focus their treatment on a specific group of patients, such as children who have been abused, victims of domestic violence, veterans, or first responders (Antonellis et al., 2006). It is also important that any department-sponsored CISM program have a leader who possesses the credentials to properly administer the program. A clinical social worker, a psychologist, or a psychiatrist would be appropriate choices for this position. It is critical that whoever fills this role have the ability to ride along with the responders on emergency incidents and to take formal classes in dealing with critical incident stress experienced by first responders.

For departments that adopt CISM programs, whether they are through a chaplain program, PST, EAP, or a higher level of care provided by professional mental health practitioners, training of those who will be taking care of firefighters is essential. For PST or CISD team members, it is suggested that each person appointed to these roles should have at least a basic two-day training course (Jones & Majied, 2009). The National Center for Post Traumatic Stress Disorder (NCPTSD) has suggested adapting the current Navy/Marine Stress First Aid training curriculum for use in the fire services (Gist et al., 2011). This program emphasizes the "7-Cs" of stress first aid. They are check, through assessing, observing and listening; coordinate, by getting help and referring to other providers as needed; cover by getting to safety; be calm, relaxed, slow down, and refocus; connect by getting support from others; competence through the restoration of effectiveness; and confidence by restoring self-esteem and hope (U.S. Navy [USN], n.d.). Training programs must also be supported by current behavioral health theory and generally focused on providing varying levels of care. Training programs must also be accessible and inexpensive for fire departments (Gist et al., 2011). In Howard County, MD, all fire officers are required to participate in CISM training. Additionally, all recruits attending their academy must take a three-hour class on helping them through crisis

management. The department's hope is that this basic training allows all fire personnel to understand what CISM is and what resources are available to them (Thomas, 2009). Educating clinicians about the specifics of firefighter stress, as well as training fire officers and the response personnel in becoming aware of symptoms of a behavioral health crisis among their peers, are also keys to a successful program ("Breaking the stigma," 2014).

It appears that there is increasing concern among fire service leadership, as well as the management of other first response agencies, about protecting the long-term behavioral health of their personnel. Although CISD programs have existed for several decades, the new focus on developing and implementing more effective programs is being addressed with the help of clinical research and the personal needs of first responders.

Procedures

The intention of this research project was to answer the questions posed about defining the elements necessary to develop and implement a CISM program which would help in the maintenance of the long-term behavioral health status of firefighters in RRFRD. In an effort to answer these questions, the author performed a contemporary literature review on the current status of CISM research and practice among first response agencies across the United States. Literature was also accessed that addressed how fire service leadership developed and implemented programs for their personnel. The search for appropriate literature began while the author was attending the EL course on the campus of the National Emergency Training Center (NETC) in Emmitsburg, MD. In addition, relevant literature was found utilizing standard and academic search engines through the Internet.

Original research was performed, which included surveys, questionnaires, interviews, and email correspondence. A 10-question anonymous survey was sent to all 104 personnel in

RRFRD through the city's email system (see Appendix A). The survey was hosted by an online survey service called SurveyMonkey.com. The questions focused on their general experiences with workplace and incident stress, as well as history with the department's current CISM program. Additionally, the responders were asked to identify the elements that were important to include in RRFRD's proposed program. The limiting factor to this research tool was that completion of the survey was not mandatory, although all personnel were encouraged to complete the survey through a follow-up email and through the department's monthly newsletter. The survey was made available to the personnel for a total of 45 days. Of the 104 firefighters who had the potential to answer the survey, 60 responded to the questions via the Internet, which represented approximately 58% of the potential respondents. Among the firefighters who responded to the survey, six reported their years of fire or EMS service was from 0-5 years, 23 stated 6-10 years, 13 had 11-15 years, and 18 reported over 15 years of service.

A second eight-question survey (see Appendix B) was distributed by email to the executive leadership of fire departments who are members of the Albuquerque Metro-Chiefs Association. Each of the 44 regular attendees of the bi-monthly meetings received a link to the SurveyMonkey.com survey. These representatives of career and career/volunteer combination departments fill the roles of fire chiefs, deputy chiefs, or other command officer positions. There were a total of 11 responses to the survey, which represented departments across the area (see Appendix C). The limiting factor to this survey was that the request was sent via official department email to the group with a letter of explanation about the project (see Appendix D), and participation was voluntary. Additionally, an email (see Appendix E) was sent to the author's classmates in the EL course they had all recently completed at the NFA through a group-address list created during the course work in Maryland. Of the recipients who were sent

the email, four responded with potential resources for current CISM programs which were considered successful by their department leadership.

Personal correspondence, either through email, telephone interview, or face-to-face interview was performed by the author with subjects deemed to have pertinent information regarding the design and implementation of fire department CISM programs. These individuals (see Appendix E) were identified either through correspondence with EL classmates, were already involved in CISM programs in the Albuquerque metropolitan area, had been identified through Internet searches for CISM resources for fire departments, or were currently associated with RRFRD.

Six firefighters from RRFRD had self-identified as having incident or workplace stress issues to the author and had approached the author requesting assistance with counseling resources through the department's EAP service, or RRFRD's chaplains. These six individuals were contacted and asked if they would participate in completing a confidential questionnaire (see Appendix F) about their experiences. Five of the six firefighters, or 83%, who had agreed to complete the questionnaire returned it by the deadline. The firefighters asked that their identity be held in confidence, so they are referred to in this project as firefighter A through firefighter E. The limiting factor to this portion of the research was that the questionnaire was not mandatory and there was a deadline for completing the short questionnaire. In addition, there may be other firefighters within the organization who had experienced or are experiencing incident-related stress; however, they had not self-identified to the author.

Lastly, it was discovered during the process of investigating the current resources available in the Albuquerque metropolitan area that a neighboring fire department to the south of Rio Rancho had been considering the development of a similar program for their personnel. Two

uniformed chaplains for Bernalillo County Fire Department (BCFD) contacted the author with a suggestion to combine resources in order to develop a more robust CISM system in the region. An extensive face-to-face interview was conducted with Chaplain Bill Henson and firefighter James Green in order to create a plan of action to accomplish this goal. Their program "Under One Badge" had already been introduced to their personnel and the department's standard operating guidelines (SOGs), as well as a brochure explaining their program, had been drafted and submitted through the BCFD chain-of-command.

Results

Firefighters, EMS personnel, and other first responders are tasked with mitigating emergency incidents which places them on the front lines of witnessing extremely traumatic events throughout their careers. Often, this chronic exposure to critical incidents can create emotional and behavioral challenges for those whose mission is to bring order to chaotic events. Although leaders in the American fire service are beginning to recognize that they must address the emotional well-being of their personnel with the same commitment as they do for physical fitness and wellness, there are limited resources available to accomplish this goal. Ultimately, the firefighter, their family, and the community can be negatively impacted by these mental health issues.

In July of 2009, the author of this research project was filling the role as the medical commander for a large public event which took place at a city park. The event, which featured music, games, and a fireworks display, was held each year to celebrate the July 4th holiday. As the hundreds of people began to settle on their blankets laid out on the grass in preparation for the fireworks show, a quick-moving severe thunderstorm moved through the area bringing heavy rain and gusty winds. There were also several lightning strikes which accompanied claps of

thunder. As the attendees ran for the cover of their cars, a call was dispatched over the department's radio system stating that someone had fallen in their haste to get to their vehicle for cover. Fire personnel and police officers began to respond to the area. It quickly became apparent that the first responders were dealing with a lightning strike incident (Herron, 2010). When the author reached the parking lot where the incident took place, it was discovered that there was a locked gate and the victims were reported to be on the other side. Grabbing medical equipment and climbing the fence, the author and two police officers arrived at the scene of a lightning strike and there were seven patients who required varying levels of medical care. Three adults and four children had been huddling under a blanked to shield themselves from the heavy downpour when the lightning struck in the middle of the group. Two adult patients were in cardiac arrest. The three responders began to perform cardio-pulmonary resuscitation (CPR) and provide airway management while heavy rain continued to fall. Additional responders were faced with cutting the locks on the gate and arrived shortly thereafter to assist in the care of the seven patients. The father of the family succumbed to his injuries and the mother survived, but with significant neurological deficits. The remaining family members suffered various physical injuries including temporary neurological deficits, burns and ear-drum lacerations. The weather, patient access issues, the severity of the injuries, the number of patients, and the presence of injured children created an atmosphere of emotional strain for the responders that night. A debriefing held several days later with the department chaplain produced little relief for some of those who provided care to the seven people struck by lightning.

A little over a year later, a ten-month-old boy fell out of a moving car, driven by his mother, and was run over by one of the car's wheels (KOAT TV, 2010). RRFRD responders arrived on the scene of this tragic accident to find the toddler lifeless in the street with police

officers performing CPR on him. Although significant resuscitation efforts were attempted, the boy was pronounced dead after arriving by medical helicopter at the hospital. Although considered a significantly emotional scene, first responders, including the firefighters, police officers, and helicopter personnel did not hold a debriefing or after-action review of the incident. There was no discussion of emotional stress associated with the accident.

These are only two examples of highly emotional emergency calls which could create emotional strain on first responders and may prove to add to the chronic mental health issues suffered by many of these emergency personnel. In a survey of RRFRD firefighters, over 78% reported that they had experienced stress or another negative emotional reaction during their time as an emergency responder. When fire department leaders from the Albuquerque metropolitan area were asked if any of their personnel had been diagnosed with PTSD or other incident-related issue, 90% stated yes. Additionally, 70% reported that employees missed work due to incident stress, 80% stated that they had seen a loss of productivity from personnel who had experienced incident stress, and 50% reported that firefighters had resigned or retired due to incident stress. Of the 60 RRFRD firefighters who completed the survey on incident stress, 47, or approximately 78%, indicated that they had some symptoms of stress. The question posed about how critical incident stress affects RRFRD firefighters was answered through the results from the online survey conducted for this project. Over 70% of those respondents said that they have experienced sleeplessness, at least occasionally. Moreover, 64.58% reported irritability or anger associated with incident stress. Other symptoms were also reported; most notably was that almost 23% of the respondents reported using drugs or alcohol to help with stress, while panic or anxiety, emotional numbness, and forgetfulness were all experienced by more than a third of the survey respondents (see table 1).

Table 1

Symptom of critical incident stress experienced in the past	Never	Occasionally	Frequently
Sleeplessness	17.02%	70.21%	12.77%
Irritability or anger	20.83%	64.58%	14.58%
Drug or alcohol use to help alleviate the stress	68.75%	22.92%	8.33%
Depression	68.75%	22.92%	8.33%
Failed relationship	68.09%	25.53%	6.38%
Panic or anxiety	57.45%	38.30%	4.26%
Felling emotionally numb	35.42%	37.50%	27.08%
Trouble concentrating/disinterest	38.30%	51.06%	10.64%
Fear	85.11%	12.77%	2.13%
Forgetfulness	51.06%	42.55%	6.38%

According to Jeff Dill, founder of the Firefighter Behavioral Health Network, there are many branches of grief among firefighters. Depression, PTSD, and family issues can affect a firefighter's career and home life (J. Dill, personal communication, June 28, 2014). The Bernalillo County Fire Department, located in the Albuquerque metropolitan area, experienced a significant event which brought firefighter stress to the forefront several years ago. One of the department's firefighters had barricaded himself in his home after allegedly smoking spice. When police arrived they heard a gunshot. He later surrendered to the authorities after sustaining a self-inflicted gunshot wound to his face (KOAT TV, 2012). According to department officials, this incident was the catalyst that helped to spark interest in developing a new CISM program for their personnel (B. Henson, personal communication, June 23, 2014). One RRFRD firefighter commented in the anonymous survey that "I have noticed that many FF do not complain of issues arising from calls…, from time to time, we do see others that have a hard time adjusting to

elements of the call." Another stated "stress from the job can be overwhelming at times. We burn out our medics and think it is part of the job."

According to the RRFRD survey, the reasons for the reported stress among firefighters are just as varied as the symptoms that they have experienced. A single bad call, chronic exposure to violent incidents, traumatic events involving children, shift work, and even family life stresses were all identified as potential triggers to their stress. Of these potential triggers listed, single bad call, incidents involving children, emergency response combined with family life, and shift work were all seen as creating significant stress, or at least some stress in the lives of 50-80% of these firefighters (see Table 2).

Table 2

Rate potential triggers of stress	Significant stress	Some stress	Minimal stress	No stress	Not applicable
Single "bad call" or other emergency incident	26.92%	38.46%	28.85%	5.77%	0.0%
"I've seen too much blood, trauma and death in my years as a firefighter"	5.88%	19.61%	27.45%	45.10%	1.96%
Incidents involving children	40.38%	40.38%	13.46%	5.77%	0.0%
Injury or death of a first responder in the line of duty	4.00%	14.00%	16.00%	8.00%	58.00%
Emergency response combined with the stresses of family life	15.38%	36.54%	28.85%	19.23%	0.0%
Home and family life only	9.80%	29.41%	25.49%	35.29%	0.0%
Loss of sleep due to shift work	17.31%	32.69%	34.62%	15.38%	0.0%

Often, firefighters or other rescue personnel tend to experience survivor's guilt after responding to an incident in which someone dies. This can create a negative impact on the

emotional state of that responder. “They have to realize that they did the right thing,” said Scott Mansfield, fire department chaplain (personal communication, May 27, 2014). However, there are some responders that are unable to realize that their efforts were sufficient, despite the outcome. This is when stress from home and their career, job burnout, and other issues can trigger behavioral health issues, including PTSD. “These issues are no different than a physical injury. It is just an injury of the mind,” said Shannon Pennington (personal communication, May 21, 2014). Fire department leadership must recognize that firefighters are vulnerable to these experiences and potential emotional injuries. They should focus their efforts on developing effective programs to prevent behavioral stress and address long-term firefighter mental health. However, these programs must be based on successful models as well as current behavioral health research and not on antiquated treatment modalities.

The State of New Mexico Department of Health EMS Bureau offers a crisis support team through a group of volunteer mental health professionals, clergy and peer support personnel who have completed specialized CISM intervention training. These individuals are available to be dispatched out to first responders across the state who have experienced a significant incident. The team is available on-call through a centrally located dispatch center in Santa Fe, NM. It is noted that this service is not psychotherapy or a substitution for professional mental health services. The program is aimed at intervention and prevention during the first several hours post-incident (New Mexico EMS Bureau [NMEMSB], n.d.). Historically, EMS agencies and fire departments have utilized this program when their personnel have responded to significant incidents which had the potential of creating emotional stress. By definition, this program generally provides CISD sessions with responders in a group setting in which their discussion about the incident is facilitated by the trained volunteer provider. However, there has been some

criticism over the traditional CISD programs, and many agencies have begun to distance themselves from these services.

According to Judith Bock, Psy.D, and clinical therapist from the University of Colorado at Colorado Springs (UCCS), CISD programs are no longer recommended for reducing the anxiety associated with incident stress. She noted that many agencies have been moving away from this model since 2004. Due to the fact that reactions to critical incidents are very individualized, many of those involved in CISD sessions have the potential of being exposed to additional emotional trauma through the group discussion. The incident may affect one firefighter, and not the other. “They could cross-traumatize each other,” she said. This could be especially evident when a perceived outsider is brought in to facilitate these debriefings. “The reaction among first responders tends to be lukewarm, to cold,” (J. Bock, personal communication, June 23, 2014). Deb Boehme, mental health coordinator for the New Mexico Disaster Medical Assistance Team (NMDMAT), agrees that agencies must begin to look at providing alternative therapies for first responders who may be suffering from incident stress. She stated that the industry is getting away from the words that have been traditionally used in the CISM system. “We’re changing the nomenclature of CISM, to include debriefing and defusing,” (D. Boehme, personal communication, June 28, 2014). Firefighters in Colorado Springs, CO, had become resistant to participating in CISD sessions and some were even “overwhelmed” which created negative feelings about the program (J. McConnollogue, personal communication, June 16, 2014).

In a survey of RRFRD firefighters, approximately 22% of those who had sought CISM services stated that they had utilized the state-sponsored CISD program. Of those respondents, about half agreed that the session was effective, while the other half were neutral or stated that

they did not consider it effective. When asked about their comfort level in dealing with various programs aimed at helping with CISM, 37.26% stated that they would be uncomfortable in participating in the state program. Additionally, 50% of those who responded indicated that they felt that the state program would be the least beneficial to treating PTSD or other incident-related behavioral health issues. The average ranking, on a 1-10 scale of effectiveness, the EMS Bureau's CISD program received a rating of 2.39, which was the lowest of the 10 potential services available. The respondents were asked: If you were diagnosed with Post Traumatic Stress Disorder (PTSD) or other incident-related issue, which resource do you feel would be the most beneficial to address your behavioral health needs? Please rank these resources from #1 being the least beneficial to #10 being the most beneficial (see Table 3).

Table 3

Potential CISM Provider	Average ranking
Friend	7.80
Family member	7.91
Peer (another firefighter of your rank/experience)	7.85
Company officer (Captain)	7.20
Command staff (Battalion Chief, Deputy Chief, Fire Chief)	5.07
EAP counselor	5.24
Professional counselor or physician	5.04
Clergy	3.65
Department-sponsored chaplain	2.85
CISD facilitator (State EMS Bureau)	2.39

Although many fire departments offer a variety of services which address behavioral health issues, department leadership in the Albuquerque metropolitan area have stated in an online survey that their programs are not enough to fully meet the needs of their personnel. Greg Perez, deputy chief from the Bernalillo County Fire Department, stated that there is a huge need for additional programs in this area and his department needs to focus more on providing services in-house. He added that development of these programs needs to be a top priority for department leadership. Fire Chief Erik Litzenberg from Santa Fe (NM) Fire Department wrote in his survey response that his department does not truly address the problems in most cases. “We do an OK job of people who self-identify,” he wrote. Xavier Anderson indicated that CISM programs available in the New Mexico State Forestry Division are adequate, but only if they are utilized by personnel. Reducing the focus on critical incident stress and putting more emphasis on the anticipated stresses of the job may be a more effective method of providing behavioral health resources, according to Fire Chief David Sperling from the Santa Fe County (NM) Fire Department.

Not everyone feels that the current CISD model is completely ineffective. “Some benefit has been shown with CISD,” said Darren Braude, MD. “Let’s not throw the baby out with the bathwater. CISD works fine, maybe it was the facilitator who didn’t,” he added. Braude, who is RRFRD’s medical director and director of the University of New Mexico’s EMS Medical Directors Consortium, stated that the specially-trained EMS physicians from the consortium can deploy out to fire crews who have experienced a significantly bad call and help them debrief their response. Although these physicians do not have specific training in crisis intervention, he said that the doctors can give the responders a unique medical perspective to help them deal with the consequences of the call. They can also act as a liaison with the firefighters and refer them to

a therapist or counselor if they determine that they need additional help in coping (D. Braude, personal communication, May 27, 2014). In addition, Troy Rodgers, Psy.D, director of the Public Safety Psychology Group, stated that he is not surprised that many feel that CISD programs are not effective. He said that generally CISD sessions do not necessarily relate well to first responders. Many of the facilitators for the debriefings perform sessions "straight out of the book." This, according to Rodgers is the best way to lose people and their trust in the CISD system. "Often they are too clinical or too touchy-feely, and this turns firefighters away." He added that there are several keys to more effective and efficient CISD program. The first is to use the sessions to identify those who are experiencing a continued struggle with issues. Developing a familiarity with the clinical providers would also create a more conducive atmosphere for positive results, and continued exposure to debriefings shows the responders that someone truly cares. "There are benefits if it is done the right way," (T. Rodgers, personal communication, July 24, 2014).

Departments that provide mental health support for firefighters through an EAP service or through volunteer or staff chaplains have found that there are limitations in these resources as well. As noted in Table 3 (above), when RRFRD firefighters rated the available resources to address behavioral health needs, EAP services received a 5.24 rating on a 1-10 scale, while clergy and department chaplains received a 3.65 and 2.85 respectively. Generally, there is little to no training on dealing with the stresses of being a firefighter and usually EAP services consist of a phone number posted on the wall of the station (J. Dill, personal communication, June 28, 2014). Chief Sperling added that statistics for his department indicated that EAP is not widely used by firefighters.

In a confidential questionnaire, a firefighter from RRFRD wrote that his experience with EAP was not as beneficial as he had hoped. The therapists were very nice, but they always seemed rushed and overworked. He added that just when they were able to get to the "bread and butter" of his stress issues, the sessions were up and he was sent on his way. "EAP was nice, but it just touches the surface sometimes with only five visits," (Firefighter A, personal communication, n.d.). Another firefighter (Firefighter B, personal communication, n.d.) stated that EAP helped minimally and only focused on work-related issues. Unfortunately, many of the same issues that he was facing were still evident even after the allotted five visits. He added that he doesn't feel that EAP services address deeper-rooted issues that often accompany incident stress. Firefighter C (personal communication, n.d.) agreed by noting that EAP was nothing that he had expected and that the services offered were no more than what he would get by talking to a stranger at a social event. Additionally, he wrote that these providers do not have an understanding of the issues facing first responders.

> "The counselors that conduct these sessions fail to recognize the exposure we, as first responders, have and how we all developed coping mechanisms from day-one of education/training. Our exposures contort our perception of life and how we fit in. Our values and expectations are different."

Another firefighter from RRFRD wrote that he was told by an EAP counselor that he should just continue to work in order to de-stress (Firefighter D, personal communication, n.d.). Lastly, Firefighter E (personal communication, n.d.) had a slightly different experience. During his first visit he noted that the counselor was cold and treated him as just another patient; however, in subsequent visits another counselor was very helpful and warm and allowed him to speak whatever was on his mind. He added that this second provider gave him some relaxation

exercises, offered reading suggestions, and shared some personal stories with him. “This allowed me to relate to her.”

Fire department sponsored chaplain programs are not the most popular choice for firefighters experiencing incident stress. In a survey of RRFRD firefighters, only 7.41% of those who responded stated that they had accessed the department’s chaplain. A large percentage (37.26%) were either somewhat uncomfortable or very uncomfortable with the department chaplain, while the majority (41.18%) indicated that they were neither comfortable or uncomfortable in having him involved in their problem. However, the chaplain program has shown some limited success in addressing the behavioral health issues of firefighters, but these programs are admittedly limited. According to Father Scott Mansfield (personal communication, May 27, 2014), priests in the Catholic Church receive minimal training in crisis management during their seminary education, but these limitations are known from the beginning. Chaplains must investigate the core reason why the firefighters are not able to handle the stress. Sometimes there are underlying problems that are creating the conflict. It is important that a person suffering from emotional stress talk to someone to get rid of the internal toxins that are creating the issue. If they don’t talk it out and let it go, the stress can come out in very ugly ways. “People who have faith tend to recover quicker, both physically and emotionally,” he added. Prayer and surrendering to the will of God can help a person struggling with issues make sense of it all. Jeff Dill and the Firefighter Behavioral Health Alliance work closely with department chaplains to train them in what firefighters do and how to help those in need (J. Dill, personal communication, June 28, 2014). Chaplain Bill Henson from Bernalillo County Fire Department agreed that chaplains can have a positive effect on the mental health of firefighters. During his normal tour of duty, he visits with fire personnel on a regular basis to help them maintain their

mental wellness through informal chats about their emergency response. “This lets them vent and release some of the stress that builds up by dealing with it in a compartmentalized fashion,” (B. Henson, personal communication, June 23, 2014). Along with developing and maintaining an effective EAP or chaplain program, fire department leadership must also investigate other successful avenues to address the behavioral fitness of their personnel. “EAP providers tend to work well with most city employees; however, there tends to be lack of trust among firefighters,” said Troy Rodgers, Psy.D. He added that EAP counselors and department chaplains are both well-meaning, but they have not developed the trust factor needed to be effective in helping first responders through difficult times (T. Rodgers, personal communication, July 24, 2014).

There has been a realization among firefighters that discussing incident stress or other behavioral health concerns with counselors or chaplains who do not have any direct experience in emergency response may not yield the best results in defusing their mental health issues. Street credibility, or knowing that the person they are talking to has direct knowledge and experience, can produce better communication and understanding about the issues at hand. In 2004 the Colorado Springs Fire Department (CSFD) began working in conjunction with researchers at UCCS to develop a peer support program among the response personnel to create an avenue for firefighters to discuss their feelings and stresses associated with bad calls. The peer support program utilizes a training program developed by behavioral health researchers at the university and is used to expose a select group of responders from all ranks, across all shifts, and all stations to become a support network for their peers. “It has taken us a very long time to establish with the firefighters as there was a general mistrust of department administration and the city,” said CSFD Captain Jaime McConnollogue. “Now we have a group of peer facilitators that are there as a sounding board to just listen to the concerns of their coworkers,” she said.

Currently the department has at least eight peer support personnel per shift who work in complete confidentiality with the information shared during these one-on-one counseling sessions. When the program coordinators are informed about a significant call, the program implements what is referred to as “watchful waiting.” This allows for the crews to defuse the call themselves through discussion lead by their station supervisor. In addition, the department allows for personnel to utilize personal time off if they are experiencing significant stress over the incident. The peer support program is put into action a short time later as peer support personnel usually check back with the affected crew a few shifts later to see if there are any lingering issues. If someone is having difficulty, the peer support counselor will be made available. “Usually this is helpful in getting people to open up,” McConnollogue said. “We’ve made it OK for everyone to ask for help.” The CSFD program has shown to be successful, and it is slowly becoming a more normal part of the fire service. The department begins by training personnel during their recruit training (J. McConnollogue, personal communication, June 16, 2014).

Darren Braude, MD, agreed that peer support is an important component to successfully defusing stress associated with incident response. Utilizing peers, family, chaplains, and even people from outside the department can help a responder deal with their feelings (D. Braude, personal communication, May 27, 2014). “Responders must have an avenue where they can talk to someone who has chewed the same dirt,” said BCFD chaplain Bill Henson. “We are not trying to play psychologist, we’re just giving them the tools to help firefighters get through difficult problems,” he added (B. Henson, personal communication, June 23, 2014). According to Father Scott Mansfield, it is extremely important for firefighters to talk to each other and share their experiences. Often, he said, they can coach and encourage each other to handle most of these issues. However, there are some deeper-seated concerns, such as PTSD, which require the

assistance of a professional counselor (S. Mansfield, personal communication, May 27, 2014). Jeff Dill and his organization have developed a two-step approach to dealing with incident stress. The first step involves a peer support program which helps firefighters help themselves by offering one-on-one sessions to help defuse incident stress. The second utilizes a professionally certified counselor or psychologist when these feelings are more significant. “Nobody wants to look like the weak one. Education is the key to let everyone know that it is OK to ask for help,” he said (J. Dill, personal communication, June 28, 2014).

Firefighters from RRFRD have also weighed in on the potential benefits of developing a peer support system. One firefighter wrote in a confidential questionnaire that he “believe(s) maybe a peer mediated and confidential resource would be beneficial. Using us to treat us. In my opinion, the majority of our problems are not organic but functional. If we could be offered a structured, organized, and easily accessible system (unlike CISD), I feel you would have more buy-in from responders,” (Firefighter C, personal communication, n.d.). Another firefighter voiced a similar sentiment by writing, “The things we see and react to are greater than most people will deal with. Sometimes it’s possible to internally grieve, but other times someone familiar to the job may be a great asset to our program,” (Firefighter E, personal communication, n.d.). According to RRFRD firefighters who completed an online survey, the use of a peer support program received a 7.85 rating (on a 1-10 scale) for ranking the perceived benefits of an incident stress reduction program (see Table 3). Additionally, 86.54% of the respondents indicated that they would feel very comfortable, or somewhat comfortable talking with their peers to defuse stress associated with emergency incident response. One survey respondent added, “I also think that peer support and tail-boarding the incident has always been the most beneficial.” Another provided a similar perspective: “I think the Captains or another interested

member on every crew or at least a north and south rep should be trained on basic CISD processes." Karl Isselhard, deputy chief for the Albuquerque Fire Department, stated in a survey response that peer support programs would have a great deal of benefit for the personnel serving in his department. "We have found our members do not open up to anyone other than peers. The chaplains try to help but 'do not understand' in the eyes of the members," (K. Isselhard, personal communication, May 21, 2014). Whether departments provide support through an EAP, chaplain program, or a peer support network, there are going to be instances in which the responders will require the services of a professional counselor or psychologist.

It is important for fire service leadership to recognize that there are times in which their personnel do not find the support they require at the lower level of counseling. These incidents may necessitate a higher level of care. According to material provided by Dr. Bock, psychological care for first responders must be immediate, close by, non-intrusive, and should entail a stepped-approach that matches the clinical needs of the firefighter with their treatment options. Additionally, if clinical care is indicated, the standard of care must be provided by credentialed providers who specialize in treating first responders. She added that most people given a moderate level of support will right themselves (J. Bock, personal communication, June 23, 2014). In the Colorado Springs Fire Department, prior to the development of their current program, there was no clear path for firefighters dealing with traumatic stress issues. The department, under the direction of a physician advisor for their behavioral health program, identified a local behavioral health provider group to offer their firefighters clinical care if it was indicated. The private-practice group worked closely with department leadership to develop a program which would accept their employee health insurance or through the state's workers compensation program. The behavioral health clinic which contracted with the department

provides up to eight visits, which are paid by the department. The firefighter's health insurance provides the payment if additional sessions are necessary. Department administration concluded that they would have to get approval from the workers compensation program if the firefighter's emotional stress or PTSD diagnosis was determined to be work-related. The clinic's staff is also allowed to ride along with firefighters on duty to give them a true sense of the challenges of the profession (J.McConnollogue, personal communication, June 16, 2014). Dr. Braude agreed with the need for identifying professional counseling services. "We will need to identify mental health professionals that can provide different levels of care," he said. "We don't have that top-tier established to go beyond working with the department physician," (D. Braude, personal communication, May 27, 2014).

RRFRD firefighters who have utilized the current behavioral health resources provided by the department have also stated the need for specialized clinical treatment. Firefighter E noted that he believes that counselors could better understand the firefighter's mind if they were allowed to ride along during shifts. In addition he suggested that the department designate a liaison between the counselors and the firefighters so that there would be defined system of communication (Firefighter E, personal communication, n.d.). Another firefighter stated that there needs to be a group of mental health providers who specialize in the care of first responders (Firefighter D, personal communication, n.d.). Of the 60 respondents of an RRFRD survey, only five (17.86%) indicated that they had utilized a professional counseling service, of which 80% stated that they felt the assistance they received was either very effective or somewhat effective. Due to the relatively low number of firefighters that had accessed these services, most (48%) indicated that they were neutral in their comfort level of sharing their incident stress experiences with a professional counselor. Professional counselors received a rating of five, on a 1-10 scale,

on the perceived effectiveness of this resource being able to address incident stress issues. However, not all fire departments appear to have recognized the need for providing behavioral health support from professional providers, other than the traditional EAP resource. There was 30% of the fire department leadership from metropolitan Albuquerque departments that indicated that they provide support from professional behavioral health providers.

Dr. Julia Kennedy, Psy.D, a clinical psychologist and former first responder, stated that it is important for departments to recognize the need for a behavioral health support program. She emphasized that the focus should be on prevention rather than treatment. First responders are often exposed to vicarious trauma after witnessing others who are suffering. Peer support programs will usually create the environment which will assist the firefighter with these issues; however, there are outliers present in every group. These responders may require additional support and counseling from a professional. It is critical for these counselors to know what the firefighter has experienced. The tendency is for the firefighter to think of the counselor, “You don’t know what I went through,” (J. Kennedy, personal communication, July 17, 2014). The trust factor helps in the development of a positive relationship between the first responder and the behavioral health provider. “Firefighters tend to need special treatment,” said Dr. Rodgers. “They have high expectations, are jaded, and tend to have a lack of trust.” The more the clinical counselors can be involved in their culture, the more they can become part of their world, rather than being considered outsiders (T. Rodgers, personal communication, July 24, 2014).

RRFRD firefighters, medical and mental health providers, support personnel, and department leadership from the Albuquerque metropolitan area have shown that they support a more diverse and effective behavioral health support program for firefighters dealing with incident-related stress. The question that still remains unanswered is how RRFRD should

design, implement, and deliver the program to their personnel. According to BCFD Chaplain Henson, it is important to get the program started so that the behavioral and spiritual needs of department members can be addressed. “I don’t care who drives the program, as long as these needs are met,” (B. Henson, personal communication, June 23, 2014).

When CSFD leadership determined that the CISM program they had was not as effective as they had anticipated, they began to work with behavioral health specialists to design a new, more effective program. They knew that in order for the program to be successful, it needed to be designed around individualized treatment, rather than group-based debriefing sessions. Through research conducted by UCCS, they discovered that a peer-based behavioral health program would work best for their department. The contention among the CSFD personnel was that firefighters would be perceived by their peers as someone who had mastered their craft, therefore would be better able to understand their issues. Hence, the partnership between CSFD and UCCS began to develop, implement and improve their peer support program. The first task identified was to send a group of firefighters and company officers through a one-week training course to learn how to deal with other firefighters having behavioral health issues. “They became better listeners and communicators, and they learned to recognize when to make a referral,” Dr. Bock said. Personnel who received the training were spread across all shifts and ranks. Firefighters were chosen by identifying the individuals who were the “go-to” people on the department. Most of these firefighters were thought to already have the skill set they would need to accomplish this task (J. Bock, personal communication, June 23, 2014). Although it has been difficult to convey any budgetary savings to the department or city administration, Capt. McConnollogue said that the CSFD program has potentially saved a great deal of lost personnel

time. She added that due to the passion of the firefighters involved in the program, it has proven to be a great success (J. McConnollogue, personal communication, June 16, 2014).

Dr. Braude stated that he felt that RRFRD's company officers, who serve as front-line supervisors in each station, are in the perfect position to fill the need as peer supporters. "They are in the best place to intervene early-on. This makes perfect sense as far as the first line approach to behavioral health support." He added that hand-picking first responders who have street credibility would allow for a diverse group of peer supporters to serve those in need. He equated the program to be similar to the Big Brothers/Big Sisters program. Firefighters from various departments from the region could receive the training to become a consortium of peer supporters that would be available to all agencies. By creating a large group of trained personnel available, the department would have a program in which the provider could be matched up to support their peer. "You could, essentially, identify a provider that fits the personality of the firefighter who needs help," (D. Braude, personal communication, May 27, 2014). Jeff Dill agreed with the development of a peer support program consortium approach. He said that there may be times that a firefighter may be uncomfortable with exposing their raw emotions to someone they know (J. Dill, personal communication, June 28, 2014). Within the ranks of firefighters, there is still a culture that is reluctant to accept that cumulative or acute incident stress exists among the members of the department. In order to make any program that supports the behavioral health of first responders effective, it is critical to educate firefighters that it is accepted and appropriate to seek assistance for the prevention or treatment of the signs and symptoms of stress.

"It is important to change the cultural aspect of behavioral health in the fire service," said Jeff Dill. "There has been a cultural brain-wash into how we are expected to act when we put on

that uniform," he added (J. Dill, personal communication, June 28, 2014). One RRFRD firefighter stated in a confidential questionnaire that he has seen "some people are hurting and don't feel as if they should call a CISD for fear that it might affect how people look at them," (Firefighter A, personal communication, n.d.). In the RRFRD survey, it was noted that over 78% of the respondents indicated that they have experienced a negative emotional reaction during their tenure as an emergency responder. However, there is a contention among the ranks of firefighters that they are supposed to feel bad after a critical call because it is just part of the job. However, according to Dr. Kennedy, it is not usually the job that creates these issues with firefighters. Public opinion and their expectation of how a firefighter should act is generally enough to create a behavioral problem. Add to that what's inside their minds, and the problems can increase. "It is important to educate firefighters of what is normal and not normal. Stress happens and it is pretty normal to freak out," (J. Kennedy, personal communication, July 18, 2014). Recognizing the signs and symptoms of incident stress can help firefighters identify when one of their coworkers may be experiencing emotional or mental health problems. The first step is to get the awareness of mental health out there, and the second is to begin the process of getting help for that individual (Firefighter B, personal communication, n.d.). Peer support can be a route to controlling the feelings of stress and anxiety experienced by firefighters. "Normalizing therapy through peer counseling can be enough to get them through the issue," said Dr. Bock. She added that people can be their own solution through self-monitoring, and using relaxation exercises to regulate their stress, which can help them get back to feeling on track (J. Bock, personal communication, June 23, 2014). A respondent to the RRFRD survey agreed that peer support may be the most acceptable method to address incident-related stress issues.

> "I believe a lot of the stress of the job should be handled on the job right away. I also think that peer support and tail-boarding the incident has always been the most beneficial. I think that the captains can have the greatest impact and should be given some basic instruction from a specialist to coincide with their experience in handling the stress of the job. Whether we like it or not, the captains are looked at in every situation and the crews follow with their emotions and actions. I believe that the stress on the job could be handled mostly in the station" (Rio Rancho Fire Rescue Department [RRFRD], 2014).

However, in order to avoid the stigma of seeking assistance from a behavioral health support program, it is important to provide better education programs on signs and symptoms of stress and PTSD in the fire service specifically and the exploration of alternate treatment methods (D. Sperling, personal communication, May 20, 2014). Fire Chief Travis Brown from the Las Cruces, NM, Fire Department agreed that providing education and training on the recognition of behavioral health issues among firefighters is important. He added that the departments must also provide services that address the individual needs of personnel as well as create an environment of cultural change and acceptance of accessing these services (T.Brown, personal communication, May 20, 2014).

The peer support program can be identified as a bridge between the first responder dealing with incident-related stress to finding a resource within the professional behavioral health community. It is important for the program to find providers, either professional counselors or psychologists, that are vetted to provide the specialized care that first responders require. This may require the providers to spend some time with the department on ride-along sessions to learn about what firefighters face while responding to incidents, or just knowing the intricacies of station life. In the CSFD program, potential providers receive two hours of

orientation training on the department (J. Bock, personal communication, June 23, 2014). The success of a relationship with professional providers also relies on the ability to match the provider with the individual who needs the help. A personality match would facilitate a more effective client-patient relationship (D. Braude, personal communication, May 27, 2014). RRFRD Firefighter E (personal communication, n.d.) also felt that a ride-along program would be beneficial to the program. Additionally, he suggested that the department work with multiple agencies to give firefighters a choice as to where they would receive care. Another aspect of managing a successful program is how the funding model is designed. In order for firefighters to feel comfortable in utilizing the services, the professional care needs to be easily accessible and affordable.

In Colorado Springs, the initial program design involved finding providers that would take payment for services from the city's healthcare insurance as well as the ability to accept workers compensation reimbursements (J. McConnollogue, personal communication, June 16, 2014). According to Dr. Bock, the money spent proactively to address incident-related stress could have financial considerations for the city and the department down the road. She used the example of the higher costs associated with treating more serious behavioral health issues, rather than catching them early on. "It becomes prevention verses treatment. Less severity of the problem equals less suffering by the firefighters, which equals less cost," she said. Although success of the program is anecdotal, the financial implications of losing a firefighter to an early retirement, medical leave, or even suicide can easily be over $60,000 just in the training costs for a replacement responder, she added (J. Bock, personal communication, June 23, 2014). Dr. Rodgers agreed with the potential savings that could be realized by a department by focusing on prevention rather than treatment. "The cost of preventative services can be three times less than

the cost of a fit-for-duty evaluation," he said. The more resources a department expends on prevention will create a system of budgetary savings that is exponentially greater. The loss of a responder from full duty can generate a loss of up to $50,000 in money needed to train a replacement (T. Rodgers, personal communication, July 24, 2014).

There appears to be a need for fire department administration to focus on many aspects of the development and implementation of a CISM program within their department. The program design needs to begin with a solid foundation of a well-planned peer support program and include finding professional counseling services that fit the needs and personalities of the firefighters. All of these resources need to focus efforts on understanding the issues that face first responders daily, as well as make services assessable and affordable to the individual and the department.

Discussion

Although there is some minor dissension of opinion between the contemporary literature and the findings of this research project, the general contention among behavioral health providers and fire department personnel is that incident-related stress is an issue that department leadership must address with an effective and efficient program.

The first issue that has been addressed is whether firefighters and other first responders are affected by acute and chronic exposure to critical incident stress and how that stress may present itself as a behavioral health issue. Contemporary and relevant literature, as well as this project's research findings, agree that firefighters are affected by emotional or behavioral health issues that stem from their response to emergency incidents. The manifestation of stress can appear in firefighters as loss of appetite, nightmares, anxiety, anger or hostility, and sleep disturbances ("Breaking the stigma," 2014). A disruption of normal sleep patterns, such as those

experienced by firefighters during shift work, can contribute to career burnout, cause poor job performance, impair judgment, and decrease motivation (Ballard, 2014). Study results have indicated that after a disaster or large emergency incident, first responders can experience elevated rates of depression, stress, or PTSD for months or even years after the incident. These issues may be exacerbated by pre-existing mental health problems that first responders may have. New behavioral problems could emerge as a result of exposure to the emergency (Rutkow, Gable, & Links, 2011). The literature appears to strongly support the results of project research and the RRFRD survey of responders. According to Dr. Kennedy, the images that first responders see with these significant emergency responses stay with them for a long time. “It stays in their brains and they just can’t leave that at work,” (J. Kennedy, personal communication, July 18, 2014). With over 78% of the respondents indicating that they have experienced a negative emotional reaction after an emergency response, the indication is that firefighters with RRFRD are similar to department personnel and first responders across the country. Sleeplessness, anger, drug or alcohol use, anxiety, and impaired judgment were all experienced by RRFRD firefighters, at least occasionally. When compared to symptoms stated in the literature, Rio Rancho firefighters share many of the same challenges. Firefighters in the Albuquerque metropolitan area are also affected by these same issues with 90% of the department leaderships reporting that their personnel have experienced behavioral health symptoms. In addition, 80% of the respondents who indicated that employees had shown a loss of productivity due to incident stress. Among the other indicators that incident stress is taking a toll on firefighters is a new focus on suicides among those in the fire service. An increase in reported firefighter suicides has highlighted the need for programs to assist in the stress, grief and other emotions associated with emergency response (Allen, 2011). According to Jeff Dill,

the Firefighters Behavioral Health Alliance has been working to educate departments and firefighters about incident stress and anxiety and assist in the prevention of firefighter suicide. (J. Dill, personal communication, June 28, 2014). The CSFD has also focused more efforts on prevention of firefighter suicide since the report of several firefighters who had taken their own lives in the region brought new attention to the problem (J. McConnollogue, personal communication, June 16, 2014).

Knowing that firefighters and other emergency responders are likely affected by emotional and behavioral health issues due to incident stress creates the need for a program to address these problems. Although RRFRD and most other departments have indicated that they have programs in place, there is some debate as to whether these programs are effective. There has been a new focus by fire department leadership and clinical psychologists who specialize in first responder care on rethinking the traditional methods of providing mental health care and support of firefighters. Older programs and methods have been found to be somewhat ineffective and have been deemphasized.

Some of the methods that were used by fire departments were widely accepted and implanted across the country. Increasingly many of these programs have been found to be inert, or even counterproductive through research and other clinical studies. Outdated, outmoded, discredited theories and techniques have been used to describe these traditional programs. Often there was a “disconnect” between those tasked with providing the care and the researchers who were looking into the program’s effectiveness (NFFF, 2007). Hence, many programs were used without being backed by clinical evidence that they were effective. FEMA conducted a study of firefighters who had reported exposure to critical incidents. Of the 660 firefighters included in the study, almost half had attended a debriefing session. Many of them reported that they

actually felt worse after the sessions. In another study, traumatized police officers in the Netherlands found that those who had received a debriefing showed more symptoms of PTSD than the subjects that did not (Chumley, 2012). The conclusion of a meta-analysis study from research databases found that there was "no current evidence that psychological debriefing is a useful treatment for the prevention of PTSD after traumatic incidents," (Van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002, p. 766). These research findings were similar to the contention by RRFRD firefighters that the CISD sessions historically provided by the State Department of Health have been ineffective. In the RRFRD survey, firefighters were asked with whom they would feel the most and least comfortable with in sharing their incident stress issues. Over 82% of those who responded indicated that they were neutral, somewhat uncomfortable, or very uncomfortable with a CISD facilitator from the state. Additionally, the state-sponsored program ranked last among the firefighters on whether they thought that the CISD program would be beneficial to them. Dr. Richard Gist was quoted in an article on his view of the change from group sessions to a more individualized system as an "evolution rather than a revelation," (Wilmoth, 2013, p. 8).

However, not all providers and firefighters feel that the CISD sessions are ineffective and should be discontinued. Doctors Braude and Rodgers have both stated that their opinions are that CISD group debriefings can be effective if they are led by well-trained and respected facilitators. Braude said that he has seen some good results with CISD programs (D.Braude, personal communication, May 27, 2014), while Rodgers stated that CISD facilitators must develop trust among the firefighters through familiarization of their culture and face time with them (T. Rodgers, personal communication, July 24, 2014). Of the six RRFRD firefighters who indicated that they had accessed the state's CISD program, half felt that it was either somewhat effective

or very effective. Other research tends to support the opinion that CISD programs can be effective and should be a consideration for inclusion in a comprehensive program. In the New Mexico firefighters survey, 76.60% of those who responded to the survey indicated that they had used the state-sponsored CISD program. Of those, there were over 65% who felt that the programs were at least somewhat helpful (Maxon, 2013). The debate over the efficacy of CISD programs has spurred fire department leadership to look at their programs with a critical eye. Whether inclusion of a CISD program is allowed in department programs or not, fire chiefs must realize that they are tasked with assuring that their behavioral health programs address the issues facing their personnel.

According to recent literature and research findings of this project, the development of an efficient and effective program aimed at firefighter mental health should include the consideration of a peer support program. Peer support programs have been found to be very successful in addressing the concerns of first responders. Peer support counselors tend to have the trust of their fellow firefighters, which can lead to a more open conversation (Bourgeois, 2013). In a study of North Carolina firefighters, nearly 78% of the respondents reported that they felt that the peer support interaction they had received was considered effective, with just over half indicating that they perceived the peer support program to be generally positive (Wright, n.d.). Dr. Gist also believes that firefighters receiving peer support can help in a department's effort to develop a comprehensive behavioral health program (Gist, 2009). The objective of a peer support program is to make trained personnel available when a first responder encounters a stressful situation and needs to talk to someone about their feelings. Essentially, the peer support personnel become a good neighbor. In addition peer support facilitators can serve as a department resource trained to recognize the symptoms of increased stress issues or PTSD and

recommend intervention at a higher level (Jones & Majied, 2009). Fire departments across the country have recognized the effectiveness of peer support programs and have embraced them. Among those participating in these programs are Chicago and New York City. The benefits of providing a trained peer counselor is that firefighters would have an identified person to talk to from inside their organization who can provide support and reduce their stress levels (Swanson, n.d.). The perception among fire department personnel in Colorado and New Mexico follows a similar line of thought. In the CSFD, researchers found that the peer support model was the best fit for its personnel. Peer counselors were thought to have mastered the craft of firefighting among their fellow department members. This allowed for greater trust among the membership. Individuals become empowered through the training and reliance on each other (J. Bock, personal communication, June 23, 2014). Capt. McConnollogue agreed that the peer support program was well timed and implemented. It gets people to open up and allows for the firefighters to realize that it is OK to need the help or to allow themselves to talk to someone about their issues, she said (J. McConnollogue, personal communication, June 16, 2014). A trained peer ranked similarly to a friend or family member when RRFRD respondents to a survey were asked whom they'd consider to be most beneficial in addressing a behavioral health issue. On a 1-10 scale, peers ranked 7.85, while a friend ranked 7.8 and family earned the top ranking of 7.91.

The peer support program has been shown by the contemporary literature and current research to be an effective component to a behavioral health program for firefighters. The current system in place in RRFRD includes the city-sponsored EAP and a chaplain program, both of which have shown promise for being an effective tool in maintaining the mental health of RRFRD personnel. According to Dr. Braude, peer support personnel, family, chaplains, EAP,

professional mental health providers, and the department's medical director are all considered integral to a successful program; however, training is imperative to the effectiveness of addressing the behavioral health of firefighters (D. Braude, personal communication, May 27, 2014). Groody agreed with these assumptions in that "departments must create an open environment that encourages people to come forward and speak about what is bothering them, utilize regional programs, use EAP's, create a peer support based program, and use trained counselors in conjunction with departmental physicians," (Groody, n.d., p. 23). It appears that behavioral health support programs for firefighters must be as diverse as the problems facing the first responders. Design of these programs must include varied resources to allow for the delivery of individualized help. It must then be determined how departments design and implement the delivery of programs to increase participation and their effectiveness.

Fire department leadership must prepare their membership to be both mentally and physically prepared to do their assigned tasks (Padgett, 2013). Department administration must support the implementation of these programs from the beginning. In a survey of Connecticut firefighters, over 85% of the respondents indicated that support from the department's leadership was essential to the success of a program. Almost half of those who answered the survey indicated that the peer support system would also be essential to the development of a program (Billings, n.d.). Firefighters tend to bond together because of their shared experiences with horrific scenes (Pignataro, 2013). Standing together as a department or as a group of responders appears to create strength among each other in the battle against incident stress. There is a perceived safety in numbers as firefighters and other first responders put on their uniforms and badges and face the challenges they encounter each day. Fire departments and emergency response agencies are recognizing that peer-supporting-peer systems will help in the mental

health support of their personnel; however, these services have to be accessible (Meehan, 2013). Several firefighters from RRFRD commented that “making and implementing a program would be a great start,” while another stated that they were “glad to see that this is being addressed. I hope it continues and doesn’t disappear like other projects that were brought up, then pushed under the carpet,” (RRFRD, 2014). Finding the right resource to address the specific and individual problems of firefighters and their families is critical to the success of the program (D. Braude, personal communication, May 27, 2014). It is also important to “mandate the program softly” in order to get the necessary buy-in from the firefighters and make sure that they are active participants in the program (T. Rodgers, personal communication, July 24, 2014).

Recommendations

The firefighters from RRFRD are no different than firefighters from across the nation. They are responsible for the mitigation of emergencies that occur in their jurisdiction. Among RRFRD’s assigned tasks are fire suppression, technical rescue, and emergency medical response. During these calls for service, the firefighters are exposed to emotional and often graphic scenes continually throughout their 20-plus year careers. This chronic exposure to the pain, suffering and death of others creates an environment where first responders have experienced emotional injuries and other mental health problems for RRFRD’s personnel. Admittedly, the system that has been in place to address these behavioral injuries is lacking in resources and has failed to meet their expectations of care. It is critical that the department’s administration realize this need and focus attention on modifying the program in order to meet these needs.

There are ten recommendations, which have been suggested through this project’s literature review and research, which should be considered in the development and implementation of a modified behavioral health program for RRFRD firefighters. Although the

design and implementation of a program may include these provisions, there should be consideration of other issues that may arise during the process. These recommendations are:

1. Identify a member of the command staff to lead the program.
2. Create a consortium of department personnel and mental health providers to serve as an advisory board for the program.
3. Designate and develop a contractual agreement with a local clinical psychologist to provide oversight of the program.
4. Design the program which will include the current EAP and chaplains program, as well as several new elements.
5. Create an after action review (AAR) training program for all department personnel.
6. Identify members of the department who are willing to serve as peer counselors.
7. Develop and implement a training program for the peer counselors.
8. Contract through a local behavioral healthcare provider to deliver specialized counseling services for firefighters.
9. Develop a department standard operating guideline for the behavioral health program.
10. Continue open communication and cooperative planning among neighboring fire departments so that a consortium of peer support providers is established.

The first step in the creation of this program is to identify a member of the command staff who will be given the responsibility for the administration of this program. It is the recommendation of the author that the department's EMS battalion chief be asked to assume this role as part of his assigned tasks. Battalion chief Martin Moulton is currently responsible for the management of the department's occupational medical program for firefighters. He is also tasked with serving as the health and safety officer for RRFRD. Recently, he has shown an

interest in gaining knowledge and training associated with providing counseling services. Since the annual medical evaluation provided by the fire department physician involves a cursory assessment of the firefighter's mental health, the occupational medical program appears to be a solid foundation in which to base this system. This recommendation should occur as soon as possible to allow for the program's design to begin.

The primary stakeholders who are responsible for the efficacy of RRFRD's behavioral health program are department administration, the medical director, the current chaplain program, the city-contracted EAP service, mental health providers who specialize in first responders, and the personnel who serve as the firefighters and EMTs on the front lines of emergency response. It is recommended that the EMS battalion chief lead an advisory board comprised of representatives from each of these groups. The advisory board could be established and begin to assemble by the beginning of 2015 and initiate recommendations to the Fire Chief within 90 days of their first meeting.

Similar to a physician providing medical direction for EMTs and paramedics, it is recommended that RRFRD identify and designate a local clinical psychologist who specializes in providing behavioral health services to first responders as a primary clinical advisor. The city should develop and initiate a contractual agreement with this provider to be responsible for oversight of the program. Initially, this agreement could be negotiated as an hourly rate contract; however, as the program is fully implemented and firefighters realize the benefits of the system, the contract could become broader in scope. Research from this project has identified Dr. Troy Rodgers, a clinical psychologist from Public Safety Psychology Group in Albuquerque as a potential candidate to fill this role. Due to the complexity of developing and implementing a financial agreement and the associated implementation of a fee structure, it is recommended that

this portion of the program occur during the planning for the next fiscal year. This would place a deadline for this phase of the plan to occur in June of 2015.

It has been noted that the current EAP and chaplain programs offer beneficial services to the RRFRD firefighters. The next recommendation involves the inclusion of representatives of these programs to be involved in the redesign and implementation of an updated program. The research and literature suggestes that the mental health problems plaguing firefighters across the country, as well as in Rio Rancho, are as varied as the individuals who are experiencing these issues. Therefore, it is important for the resources dedicated to address these problems to offer an individualistic approach to match the personalities of the firefighters who may be suffering from them. Members of the advisory board should plan to meet with representatives from each entity for their presence in the revamped system. An additional 30 days from the advisory board's recommendation should be ample time for these entities to meet with the board.

RRFRD's administration and training division staff should investigate a reliable source for procuring a training curriculum on an AAR program. It is recommended that all fire personnel attend training on how to conduct an AAR on each emergency response their crew has completed. The station captains will be responsible for asking the five questions associated with AARs: What was our mission? What went well? What could have gone better? What might we have done differently? And, who needs to know? The benefits of the AAR sessions is to allow each crew time to focus on their assigned duties and how they feel they performed on each emergency response. Research has shown that some of the concerns that are brought about from emotionally-charged incidents could be diminished or eliminated by an effective AAR. The AAR will become the foundation of the behavioral health program. In addition, the training curriculum presented to all fire personnel should include statements about how firefighters

should feel empowered to ask for help when they feel overwhelmed or when emotional problems begin to affect their work performance or their home life. It is imperative that the stigma associated with seeking help from a counselor be deemphasized and discouraged. This training should be delivered in June of 2015.

The literature review and the research have indicated that the success of a peer support program is partially contingent upon identifying the right personnel to serve in the roles of peer support specialists. The next recommendation is to develop a list of potential candidates from the current roster of department firefighters. These candidates should optimally be personnel that are identified by their peers as firefighters who a trustworthy, honest, and compassionate. This process could be accomplished through an anonymous online survey or through the delivery of paper ballots to all shifts and stations. The firefighters who are identified through this process would then be allowed to accept or reject their inclusion in the program. It is important that the peer support specialists be spread across all shifts and include personnel from all ranks; however, it should exclude command staff (rank of battalion chiefs and above). This process should be implemented upon approval of the plan and be in place by January, 2015.

In order to implement a peer support system, those involved as peer support specialists will need to receive training on conducting defusing sessions, recognize the signs and symptoms of emotional and behavioral issues, and how to refer firefighters to the available resources in place to help them with their mental health needs. Additionally, the training should include how to identify the emergency incidents that could produce a negative emotional response from firefighters. It is then recommended that due to the success of the program in place at the CSFD, RRFRD administration contract with Dr. Judith Bock from the University of Colorado at Colorado Springs to provide the 40-hour training to all of the peer support specialists, as well as

members of the program's advisory board. This will allow members of the board to have a broad knowledge of the program and base understanding of how the peer system will work. The process of contracting with Dr. Bock should be completed by January of 2015 with the goal of training the peer support specialists by July of 2015.

The literature review and research revealed that most of the emotional issues stemming from emergency responses that firefighters experience could be mitigated through a strong AAR and peer support system; however, there is a small percentage of responders who are at risk for developing PTSD or have underlying psychological issues or significant domestic issues that may require the help of a licensed counselor or clinical psychologist. It has been shown that the lack of understanding from the city's contracted EAP service has left many first responders feeling that their issues were unresolved. Finding counselors and psychologists who have a basic understanding and familiarity with RRFRD responders could produce a more successful system. It is recommended that the city contract with Public Safety Psychology Group to provide EAP services to RRFRD firefighters. In addition, the clinicians from Samaritan Counseling Center, where Dr. Kennedy serves as a psychologist, be identified as vendor of choice to provide counseling services. The Samaritan group accepts the medical insurance from both of the city's insurance providers. It is imperative for the providers from both organizations be integrated into the social fabric of the fire department through a regularly scheduled ride-along program and station visits. Since both of these agencies' involvement in the program includes the potential of contractual agreements and funding, it is recommended that these arrangements be fulfilled by the beginning of the fiscal year, which is July of 2015.

Prior to the implementation of any program, it is recommended that RRFRD develop and implement a standard operating guideline (SOG) to use as a tool for department members to

follow to direct their actions or decisions. The SOG for the department's behavioral health program should be designed and drafted by the principal stakeholders involved in the advisory board. The SOG draft would need to be reviewed and vetted through the department's administration and the union's executive board. The timeframe for the development of an SOG should fall in line with many other elements coming together in July of 2015.

Lastly, in order to facilitate inter-departmental cooperation and resource sharing, RRFRD should keep the lines of communication between the administrators of the department's behavioral health program and neighboring departments. It was noted by RRFRD's medical director that there will be times when a firefighter is in need of some peer counseling and may not want to be forthright with personal information with someone they know. It will be beneficial to the program's success that multiple agencies share resources through each department's program. Facilitation of training could occur cooperatively with peer support specialists from all departments. This would allow for all peer support personnel to receive similar training and could potentially be economically beneficial to host larger classes of students from multiple agencies.

Fire department leaders are beginning to focus more of their efforts and financial resources to address an issue that has been plaguing firefighters for decades. Hushed tones were typically used to talk about mental health problems among active duty firefighters. Becoming stressed over witnessing tragic events was thought to show a sign of weakness; however, firefighters and other first responders are active participants to horrific tragedies, and their emotional well-being can be negatively affected by acute and chronic exposure to these scenes. Development of a sustainable behavioral health program in RRFRD should be a priority for department leadership. The resources that are currently available or ones that could accessed

locally or regionally have the potential of building a strong system with a variety of behavioral services to address the diversity of problems that may exist among response personnel. The program should begin with a strong foundation based on an AAR system and a peer support network, then build with the elements of EAP and department chaplains. The pinnacle of the program should include professional mental health providers who specialize in first responder issues and can become a staple in the daily culture of the RRFRD firehouse. The ultimate goal of a revamped and redesigned behavioral health support system for RRFRD personnel is to provide for the wellness and safety of first responders so that they may continue to answer the call of those in need in the communities they serve.

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Appendix A

RRFRD Responder Survey

RRFD Incident Stress

1. Please indicate your years of service in the fire or EMS services.
    a. 0-5 years
    b. 6-10 years
    c. 11-15 years
    d. Over 15 years

2. Have you ever felt that you have experienced stress or another negative emotional reaction during your tenure as an emergency responder? If you answer "no" please skip the remaining questions. If you answer "yes," please continue with the remainder of the survey.
    a. Yes
    b. No

3. Which symptoms of critical incident stress have you experienced in the past? Choose all that apply.

	Never	Occasionally	Frequently
Sleeplessness			
Irritability or anger			
Drug or alcohol use to help alleviate the stress			
Depression			
Failed relationship			
Panic or anxiety			
Feeling emotionally numb			
Trouble concentrating or disinterest			
Fear			
Forgetfulness			
Other (please specify)			

4. Rate the following potential triggers of the stress or emotional or other emotional reaction you may have experienced:

	Significant stress	Some stress	Minimal stress	No stress	Not applicable
Single bad-call or other emergency incident					
"I've seen too much blood, trauma and death in my years as a firefighter"					
Incidents involving children					
Injury or death of a first responder in the line of duty					
Emergency response combined with the stresses of family life					
Home and family life only					
Loss of sleep due to shift work					
Other (please specify)					

5. If you experienced stress or another emotional reaction, did you seek counseling or other debriefing sessions (formal or informal) to help you deal with the reaction?
    a. Yes
    b. No

6. If you answered yes to the previous question, which service(s) did you use or participate in? Choose all that apply and whether you felt it was effective or not.

	Yes	No	Very effective	Somewhat effective	Neutral	Somewhat ineffective	Very ineffective
"Tailboard" or station house debriefing with your crew							
City-sponsored Employee Assistance Program (EAP)							
Department Chaplain Program							
Visit with other clergy							
Talk to a friend or family member							
Professional counseling services							
State EMS Bureau sponsored CISD session							
Other (please specify)							

7. With whom would you feel the most and least comfortable in sharing your stressful experiences?

	Very comfortable	Somewhat comfortable	Neutral	Somewhat uncomfortable	Very uncomfortable
Friend					
Peer (another firefighter of your rank/experience)					
Company officer (Captain)					
Command Staff (Battalion Chief, Deputy Chief, Fire Chief)					
EAP Counselor					
Professional Counselor or physician					
Clergy					
Department-sponsored Chaplain					
CISD facilitator (State EMS Bureau)					
Other - not listed above					

8. If you were diagnosed with Post Traumatic Stress Disorder (PTSD) or other incident-related issue, which resource do you feel would be the most beneficial to address your behavioral health needs? Please rank these resources from #1 being the least beneficial to #10 being the most beneficial.
    a. Friend ___
    b. Family member ___
    c. Peer (another firefighters of your rank/experience) ___
    d. Company officer (Captain) ___
    e. Command staff (Battalion Chief, Deputy Chief, Fire Chief) ___
    f. EAP counselor ___
    g. Professional counselor or physician ___
    h. Clergy ___
    i. Department-sponsored chaplain ___
    j. CISD facilitator (State EMS Bureau) ___

9. Please feel free to make additional comments here about your past experiences with Critical Incident Stress Management, or what considerations should be addressed in designing new program elements for future incidents. _____

_____

_____

Appendix B

Albuquerque Metro Chiefs Association Survey

Questions for Fire Department command staff:

Name: _____ Title: _____
Department: _____ Number of employees: _____

1. Are you aware of any first responder in your organization that has experienced Post Traumatic Stress Disorder (PTSD) or other incident related stress issue? *Yes or No*
    a. Have any of your employees experienced a loss of work days associated with incident stress issues? *Yes or No or Unknown*
    b. Have any of your employees experienced a decline in their productivity associated with incident stress issues? *Yes or No or Unknown*
    c. Do you know of anyone in your organization (past or present) that retired or resigned due to incident stress? *Yes or No or Unknown*

2. Does your department and/or employer offer services to address the behavioral health needs of first responders dealing with incident stress? If so, please list them below (i.e. EAP, Chaplain Program, peer counselors, etc.):

3. Are these services provided at a cost to the first responder (i.e. paid for by employer, covered under their healthcare insurance, paid for by the responder, etc.)?

4. Do you feel that these services are adequate and meet the expectations of the first responders who utilize them? Please explain your answer:

5. If you were to redesign a Critical Incident Stress Management (CISM) system, what elements do you feel would be critical to successfully address the needs of your personnel?

6. If you have an in-house CISM program, peer counselors, or a Chaplain program, how do these individuals receive training in order to effectively perform their tasks?

7. Please feel free to add any additional comments regarding CISM services or experiences that you are able to share:

Appendix C

Responding Departments to Metro Chiefs Association Survey

1. Albuquerque Fire Department
2. Bernalillo County Fire Department
3. Albuquerque Ambulance Service
4. New Mexico State Forestry
5. New Mexico Fire Marshal's Office
6. Santa Fe Fire Department
7. Santa Fe County Fire Department
8. Village of Los Lunas
9. Las Cruces Fire Department
10. Rio Rancho Fire Rescue

Appendix D

Letter of Request for Survey Response to Metro Chiefs Association

Good Day,

I have just completed the classroom portion of my final Executive Fire Officer Program (EFOP) course through the National Fire Academy. As many of you know, each class requires the completion of a research project which addresses a problem or issue within our own departments. This year, I have chosen the development of a more effective CISM program in Rio Rancho.

If you could please take a few moments and complete a very short survey for my project, I would appreciate it greatly. This survey will be open until the end of June to give you ample opportunity to complete it. If you have any questions about this survey, or my project, please feel free to contact me.

In addition, if you have any written policies and/or SOG/SOPs regarding CISM or CISD programs that you are willing to share, please feel free to forward them to my email.

https://www.surveymonkey.com/s/HMBNK5C

Thank you again for your time and consideration.

Paul Bearce, MS, NRP
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Rio Rancho Fire Rescue
1526 Stephanie Road SE
Rio Rancho, NM 87144
Office: 505-891-5928
Cell: 505-917-6617
“Protecting Your Family”

Appendix E

Letter of Request for Information to Executive Fire Officer Students

Good day everyone,

My ARP for EL is based on developing a more robust CISM system in our department. My focus will be on creating a peer-counseling system to help address problems early on after a significant incident or from long-term exposure to traumatic events.

My request is to find out if any of you, or do you know of an agency that has developed a peer-counseling program for CISM. If you do know of a program, could you please send me a contact for the agency that I may contact to get info on your/their program?

Any assistance would be appreciated.

Thanks and good luck with your projects.

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“Protecting Your Family”

Appendix F

List of Interviewees and Dates of Interviews for Project

1. Shannon Pennington, founder of Firefighter Veteran blog, 05/21/14
2. Father Scott Mansfield, RRFRD Chaplain, St. John Vianney Church, Rio Rancho, NM. 05/27/14
3. Darren Braude, MD, EMT-P, Medical Director RRFRD, Rio Rancho, NM. 05/27/14
4. Jaime McConnollogue, Captain, Colorado Springs Fire Department. 06/16/14
5. Bill Henson, Chaplain, Bernalillo County (NM) Fire Department. 06/23/14
6. Judith Bock, Psy.D, advisor and researcher, University of Colorado at Colorado Springs. 06/23/14
7. Deb Boehme, mental health clinical coordinator, New Mexico Disaster Medical Assistance Team, Albuquerque, NM. 06/28/14
8. Jeff Dill, founder of the Firefighter Behavioral Support Network. 06/28/14
9. Julia M. Kennedy, Psy.D, Samaritan Counseling Center, Albuquerque, NM. 07/18/14
10. Troy Rodgers, Psy.D, Public Safety Psychology Group, Albuquerque, NM. 07/24/14

Appendix G

Questionnaire for RRFRD Responders Who Sought Counseling

Questions for first responders who have experienced incident stress:

1. How many years have you been involved in fire and EMS services?

2. You have indicated that you have experienced stress associated with emergency response to emergency incidents. How did you initiate the access to counseling and/or debriefing services through your employer (i.e. through your chain-of-command, HR contact, etc.)?

    a. Was your employer responsive to your request? Briefly explain.

3. What services did you access in your quest to deal with your incident stress issues?

4. Did these services meet your expectations and needs? Why or why not?

5. Did the counselor or CISD mediator offer any advice that you considered helpful? Why or why not?

6. Was there any suggestion of follow up sessions or referral to another agency/provider?

    a. If so, did you make an appointment for additional session or follow up visits?

7. Do you feel that the program the City and the Department have in place is sufficient to meet the behavioral health needs of the responder? Why or why not?

8. If you were to design a different program to address these issues, what elements do you feel would be beneficial to the providers that are experiencing incident-related stress?