LifeNet

Volume 26 - Number 2

INSIDE:

LifeNet

Is a publication of the International Critical Incident Stress Foundation, Inc.

ICISF is a non-profit, non-governmental organization in special consultative status with the economic and social council of the United Nations.

3290 Pine Orchard Lane
Suite 106
Ellicott City, MD 21042
Tel: (410) 750-9600
Fax: (410) 750-9601
Emergency:(410) 313-2473
www.icisf.org

Thoughts on CISM and Resilience from a New Fire Chief

By Fire Chief Steve Dongworth, City of Calgary, ICISF Approved Instructor and Member

Since getting into fire service senior management in 2000, I have had to take a step back from front line delivery of CISM services to members of the Calgary Fire Department. However as is often the case in life, when one door closes, other doors open. One such door that opened meant that I have had the opportunity to serve on the Advisory Board of our CISM program as the Management representative. The greater door that opened was to expand my volunteer activities as a CISM provider to smaller agencies outside of the Calgary Fire Department. These agencies, often in small rural communities, have little in the way of resources for their responders after traumatic events and often have great need for assistance when bad things happen.

Over the years this has allowed me, along with other dedicated volunteer peers and mental health professionals, to travel up to about 3 hours outside of our city, usually in the evening or at the weekend to provide CISM services. This opportunity has truly stretched and developed my skills as the dynamics in these communities' present unique challenges to CISM providers. Rarely can one assemble the desired amount of information about the incident, the group or individual, or what else has been going on in the community, response organization or

Continued on page 6

One of Our Own

By Mandy Barnett

In the fire and EMS department we become a family. We work 24 hour shifts several times per week with the same people. We work hard and play hard. We share holidays, meals and sleep in the same room. We know their families, attend their kid's ball games and birthday parties. We support them during the rough times and share their enjoyment of the good times. On calls we work as a tight-knit team. We anticipate each other's moves and can talk without speaking. We enter scenes that are less than safe and drive fast with citizens who don't appreciate the driving laws. Our safety is in each other's hands.

I am trained to care for others both as an ICU RN and Paramedic. I have the alphabet soup after my name. I have held people as they die and pulled many back from the brink of death. I have seen things that nobody should ever have to see, but I'm trained to talk it out and move on. During my 13 years in EMS and 6 years as a nurse this has worked for me.

Not this time.

It was like any other shift. My partner and I had finished our daily chores, had run a few calls, and were goofing off like usual. Suddenly he sat down, put his head in his hands, and stared at the floor. I jokingly said "come

Continued on page 8

Regional Conference Calendar

August 20-23, 2015
-Denver, CO
Mayflower Crisis Support Team

October 15-18, 2015
-Seattle, WA
Seattle Police & Fire Peer Support Team

November 11-15, 2015
-Baltimore, MD
ICISF

December 3-6, 2015
-San Diego, CA
San Diego CISM Team

Check our Website for updated information on course offerings!

Submit a Letter to the Editor! ICISF welcomes comments from our readers. Please submit your comments to the editor at (lifenet@icisf.org)

Like ICISF on Facebook!

CISM in the Fire Service:

An Analysis of Stress Management in the Fire Serivce

By Robert C. Simmons, FO; Assistant Fire Chief

A firefighter's every day is someone else's worst day. The fire service, by its very nature, is a stressful profession. Fire service professionals are asked to observe and quickly mitigate extremely traumatic situations, all while spending long periods of time away from their loved ones. As of the date of this writing, the Firefighter Behavioral Health Alliance [FFBHA] (www.ffbha.org) reports that 277 firefighters in the U.S. and Canada have committed suicide between 2012 and now. However, these numbers are likely on the low side. Jeff Dill, the founder of FFBHA, estimates that only 25% of all firefighter suicides are reported to his organization. Additionally, there is no other tracking apparatus available on the national level to compile such data. Dill estimates that when this is factored into the figures, the fire service is likely losing 325 firefighters per year to suicide. Clearly, the subject of behavioral health in emergency services is one that warrants research and discussion.

I sought to gain a better understanding of the problem by examining the prevalence of symptoms amongst firefighters and the effectiveness of current stress management protocols being used in the profession. To do so, I studied the prevalence of behavioral health issues in the fire service and how they relate to formal critical incident stress management programs in the profession; the likelihood of a firefighter utilizing a stress management program; and what stress management practices could be applied to the fire service. In conjunction with a literature review, an anonymous two-part survey was conducted on a random sampling of firefighters (N = 32). The survey was used as a quantitative measure of critical incident stress management

Continued on page 9

CISM Support for Members Affected by Edmonton's Mass Homicide

By Serge Soucy, Edmonton Police Service CISM Team

Two days before New Year's and Edmonton, Alberta gets rocked with a mass murder the likes of which it has never, ever seen. Police officers converge on two, then finally three scenes and find dead bodies at each scene. Although each scene has its own horribleness about it one scene in particular is beyond the scope of even what a well-seasoned officer would consider over the top.

As a matter of policy and, more importantly, good working relationships with our leadership, our CISM team was notified almost immediately and was able to get to the effected members' divisions in time to catch them as they were coming back from the scenes. Defusing's were conducted with the initial members, this opened the door for natural follow-ups with each of those members.

Then the real work started in determining how many officers were involved in the entire investigation, who they are, where they work and to what level were they exposed to the scenes and witnesses. All told 79 sworn and 11 non-sworn members are involved to some degree or another. The Edmonton Police Service has 38 ICISF trained members on its CISM Team, and most of them were activated for this event. Two defusing's, 3 CMBS, 5 CISDS and countless 1:1's and follow-ups later. The call is still talked about throughout the service.

The swift response by our CISM Team to reach out and connect with members they already know in the variety of ways

Continued on page 10

From the Hotline Team Coordinator

By Reverend George Grimm

DID YOU KNOW:

CISM teams that are interested in being made available to the ICISF HOTLINE are listed in a database to which the HOTLINE dispatchers and ICISF staff refer when they receive requests for assistance. The basic requirement for teams desiring to be listed in this database is to file a "Team Information Form", including basic contact numbers and other required information, with the ICISF office at hotline@icisf.org

Effective January 1, 2015 the following designations of teams will be used:

- A team which simply submits the Team Information Form with the information as requested on the form will be considered an ICISF Hotline Team.
- By submitting a Verification Packet which requires additional information such as the team mission statement, team policies and procedures, training practices, member qualifications required by the team and other information, and is signed by the team officers, the team may become designated as an ICISF Verified Hotline Team. After review and approval by ICISF, this "verified" information is used to more closely match the appropriate team to fit the criteria for a specific HOTLINE request.
- A team may, in addition to the above designations, become an active member of the Foundation to receive discounts for ICISF training, quick access to the latest information, consultations and other benefits by completing a Membership Application along with the required fee.

ALL TEAMS must submit an annual form with updated contact and activity information. It is imperative that ICISF have current information when responding to requests for assistance. Teams that do not submit an annual updated form will be indicated as "Not updated". If no report is submitted by a team for 4 years, the team may no longer be considered for referral purposes.

NOTE: The old designation "Registered Team" will be replaced by the "Verified Team" designation, and current "Registered" teams will be changed to the "verified" designation.

ICISF values all teams' participation in the HOTLINE database; however, we cannot, in good faith to those accessing the HOTLINE, provide information to callers that may be inaccurate.

A reminder is emailed to teams as there update is nearing.

Thanks for your help, contact me at hotline@icisf.org if you have questions,

George

SAVE THE DATE

2015 CIMA Conference

CIMA
CRISIS INTERVENTION AND MANAGEMENT AUSTRALASIA

Yes, it's that time again! CIMA's Conference Sub-Committee is busy working behind the scenes to bring yet another outstanding Conference to our peers. This year's Conference, **Crisis Response Across the Community: Learning from Experience** will be held in Melbourne on Monday the 30th of November and Tuesday the 1st of December at the City Town Hall.

Further information will be released as soon as possible, but in the meantime, block out these dates in your diaries and watch this space!

Share Your Team's Milestone with *LifeNet* Readers

ICISF would like to acknowledge CISM Teams that have reached significant milestones in organizational longevity (i.e. five, ten, fifteen year anniversaries, etc.) in future issues of *LifeNet*. If your team reached such a significant anniversary this year, please contact George Grimm, ICISF CISM Team Coordinator (via email at hotline@icisf.org) and provide the appropriate information so we may proudly list your Team in a future *LifeNet* and provide a Certificate of Appreciation.

"Compassion is not a relationship between the healer and the wounded. It's a relationship between equals. Only when we know our own darkness well can we be present with the darkness of others. Compassion becomes real when we recognize our shared humanity."
- Pema Chodron

ICISF 2015 Academy of Crisis Intervention Scholarship Fund Award Winners!

At the International Critical Incident Stress Foundation, we recognize and applaud your sacrifices to help others. From first responders, to health care providers, educators, and everyone else that we serve, the ravages of critical incident stress knows no boundaries and you are truly "Helping Save the Heroes!"

Always in the forefront of delivering quality CISM training, the ICISF has recognized a need, and has established a scholarship fund for full and partial scholarships to assist individuals who are unable to attend ICISF training due to financial constraints, the opportunity to attend the World Congress or one of our Regional Trainings held each year. We believe that through this fund, we can continue to increase the opportunity for this vital training for many deserving individuals for years to come.

While the fund is still in its infancy, thanks to the generosity and support of our members and other supporters, we are excited to announce that we have provided four (4) scholarships to either the main World Congress or one of our Regional Trainings scheduled for 2015.

We were tremendously excited to have received a multitude of scholarship applications and the selections by our committee were extremely difficult. Each and every applicant was truly deserving, however, we could only select four.

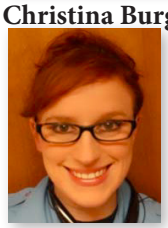
The Scholarship Award Winners for 2015 are:

Maria Bras - Professor, University of Algarve

Volunteer Psychologist for District the Police Department - Algarve, Portugal

Maria will utilize the training at the 13th World Congress to bring her new skills, learn new methods and exchange experiences with colleagues working in the field. This training will also assist her in her volunteer efforts working with the local police and the community.

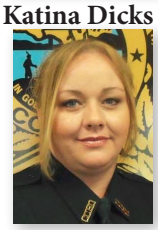
Christina Burgess - EMS Paramedic



Greenville County, South Carolina

Christina is currently a member of the Peer Support Team for the Greenville County Emergency Medical Services. Christina states that the training at the 13th World Congress will allow her to further her knowledge on CISM in emergency services that will allow her to better serve her peers and her community.

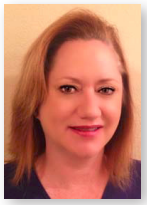
Katina Dicks - Patrol Lieutenant



Columbia County Sheriff's Office, South Carolina

Lt. Dicks' agency does not currently have an organized CISM Team. Over the past several months, Lt. Dicks has been gathering information, collecting stats, and working on a presentation to deliver to her Command Staff in support of creating a CISM or Peer Support Team.

Melissa Melton - RN, Trauma Program Manager



Shannon Medical Center - San Angelo, Texas

Melissa believes that their staff, from the front-line through discharge, needs to have the resources of CISM and Peer to Peer Support available to them. "It's different for everyone, but everyone takes a piece of the incident home with them." Melissa's longterm plans are to have the ability to plan a comprehensive approach to stress management for all staff members, but particularly the high-risk areas such as Air Medical, the Emergency Department, Intensive Care, and front line registration.

Congratulations to all of the Academy of Crisis Intervention Scholarship winners for 2015!

Our Scholarship Fund continues to grow thanks to the support of caring individuals around the world who have donated and made this scholarship program possible!

Thanks to our generous donors who are truly making a difference!

CONTRIBUTOR

Fred Dettwiller

SUPPORTERS

13th World Congress General Session Presenters

National Association of Emergency Medical Technicians

ICISF 2015 Academy of Crisis Intervention Scholarship Fund Award Winners! (Cont'd)

DONORS

Albert McQueen	Mac Stinson	Gary Brown
Cathy Demers	Mitzi Cheldelin	Theodore Lewandowski
Cheryl Novak	David Hedrick	Madeline Tompkins
J. Larry Lowe	Lisa Stone	Karen Bune
Joan Durling	Sandra Johansen	Govan Martin
Martha Pearse	Francis Sullivan	James Tucker
Edith Edde	Karen Adamson	Darrel Coons
Barb Ertl	Lisa Joubert	Thomas Moriarty
Dennis Potter	Janet Sweeney	Carolyn Uhlin
Susan Elben	Roger Bailey	Douglas Cyr
David Evans	Sheila Kaur	Kawakami Moritoshi
David Price	Paul Tabor	Jutta Unruh
Christina Mays	Jim Baxendale	William Dahlquist
Robert Fonte, Jr.	Isabelle King	Brenda Morrissey
Ron Richardson	Peter Teahen	Cheryl Walter
Bonita Frazer	Richard Bloch	Elizabeth Dansie
Destiny Sargeant	Joanne Krug	Keara Nadeau-Grandy
Patricia Tritt	Brenda Tillman	Amy White
Michael Friedman	Jill Boyd	Deirdre DeLong
Naranjan Singh	Kim Leroy	James Nelms
John Gallagher	Rick Toldo	Hagiwara Yoshitoski

Shining Star Program

ICISF is proud to announce a new recognition program entitled "Shining Star" in CISM. Current CISM Teams or Liaisons may nominate a local person who has, over seven years or more of CISM experience, shown outstanding leadership/ innovation for their efforts in promoting CISM. The Categories and Eligibility for this program are as follows:

Rising Star: Those individuals who have shown seven years of dedication, commitment and enthusiasm towards the mission of ICISF and CISM.

Guiding Star: Those individuals who have, over eight or more years of involvement in CISM, shown dedication and commitment to those in need, mentoring others to become involved in CISM, through training, team building and team support.

Heavenly Star: Those individuals who made significant contributions to the field of CISM and have left us far too soon.

Nominations will be evaluated by a committee comprised of Pete Volkmann from New York, Sandy Scerra from Massachusetts, Dennis Potter from Michigan and Mary Schoenfeldt from Washington State. This committee is independent of the ICISF office.

Announcements will be provided by ICISF on their webpage and in *LifeNet* Newsletter. This program will recognize the grass-roots efforts and successes of CISM worldwide. The recipient being honored will receive a special pin and a Proclamation from ICISF. Please nominate those shining stars in CISM. We need to know.

Complete the nomination form and forward to Michelle Parks (mparks@icisf.org)

Comments, Questions or Suggestions

Please direct any comments or questions regarding the contents of this issue to the attention of Victor Welzant, PsyD, Editor, at lifenet@icisf.org. Letters to the Editor are also welcome.Have an idea for an article in a future issue of *LifeNet*? Send your suggestions to the attention of Michelle Parks, Content Editor, at lifenet@icisf.org We welcome your input. **Thank you!**

If your article is approved and used in an issue of the *LifeNet* you will receive a complimentary Level One-1 year ICISF membership ($50.00 value)

Make Sure We're Able to Stay in Touch!

To be sure ICISF emails get through to your inbox, be certain to add ICISF email addresses to your address book. If you have a spam filter, adding ICISF.org to your "white list" of acceptable senders will also help to ensure that our emails get through. Thanks!

From the Approved Instructor Department

The following participants completed the Group Crisis Intervention Instructor Program in Atlanta, GA March 6-8, 2015. Please congratulate these new instructors!

Dwight Bain
Thomas Beddow
Dave Boyer
Kenneth Brown
Sharon Clark
Anne Daws-Lazar
Lisa Eggebeen
Frank Fuscellaro
Renee Godoy
Evangelina Hammonds
Gary Holden
Jeff Howell
Creston Hullet
Terry Hunt
Sharon Israel
Kelly Jones
Wanda Keener
Hans Larsen
Ray Lotty
Laura Lyman
Sandra Lynch
Christopher McClelland
AJ Moore
Victoria Syren
Alex Trinchet
Debby-Lyn Sabo
Mirta San Martin
Johnnathan Ward
Angie Wagar
Lourdes Wilson

Thoughts on CISM and Resilience from a New Fire Chief

Continued from page 1

lives of individuals that is relevant to the intervention. Also the dynamic of small communities where often casualties/victims are well known to responders and responders are also sought out by community members after an incident to glean information that is not publicly known. The other dynamic, particularly in the volunteer fire service is how many young people of 18 or 19 have made the commitment to serve their community but are often faced with terrible events early in their service that they are neither prepared for, nor do they always have the life skills to guide them through these difficult situations.

The range of types of incidents that these small communities experience is very broad from the expected types such as fires, MVC's, and medical calls through to the less frequent community floods, workplace/industrial accidents, and suicides, both of community members as well as fellow responders.

Other frequent challenges of these interventions is the frequency of working with a larger group than expected, participants arriving after the intervention has started and the team arriving to find a heterogeneous group when expecting a homogenous group. And all of this is after working extensively with local contacts to try and ensure a smooth operation. A final frequent challenge of working in this type of environment is identifying the local resources in smaller communities that can be passed on to personnel and supervisors for referrals and further support of those needing added help after the intervention.

As I said earlier these challenges all lead to team members getting ever stronger in using their skills when dealing with a wide variety of challenges that they might never encounter when working in the more predictable environment of their own

organization. And I acknowledge that for some of you reading this all of the above challenges will in fact be your normal world, iif that is the case I take my hat off to you and recognize you for the added complications that you encounter performing what is already difficult work.

As is the case in many other organizations and countries a major focus currently in first response organizations in Canada is around the prevalence of suicide. In Western Canada this has been brought home to us with a number of recent instances of suicide. In our organization we are aware of two members who have attempted suicide recently. In our sister city in Alberta they have experienced 2 suicides of firefighters within the last 6 months or so. We recently sent representation to a service funeral for a firefighter in British Columbia whose suicide had been attributed to PTSD. And just over the Easter weekend I worked with other volunteers to debrief fellow members of a 19 year old firefighter who took his own life. Even whilst writing this article I was made aware of another firefighter suicide in British Columbia.

From all of this tragedy the real learning is that beyond having CISM, a solid response program after trauma, the real work has to start in building greater resilience in our people long before they need emotional first aid. Of course, the ICISF acknowledges the need for this in the "Resistance, Resiliency, Recovery" continuum of care model. In Canada a really positive advance was the release of Canadian Standards Association CSA 1003 – Psychological Health and Safety in the Workplace. This national standard, although voluntary at this time, set a standard for all employers to consider in creating a safe and healthy workplace from a psychological perspective. It brought some of the discipline and rigour previously applied to physical health and safety, environmental and quality management to the field of psychological health and safety. It requires employers to identify risks to psychological wellbeing in the workplace and then to take significant steps to either eliminate, mitigate, or manage those risks as well as requiring that they have a plan for appropriate response when trauma occurs. The standard includes tools guiding an employer through the process of identifying risks, risk mitigation and management, and response. My hope is that this at minimum becomes the standard of care and at best becomes mandatory.

And now the Calgary Fire Department is preparing to pilot a program called Road to Mental Readiness (R2MR) later this year. The program was initially used by the Canadian Forces and then the Royal Canadian Mounted Police. The Calgary Police Service has started to use the program also. We have taken the decision to modify the program so that scenarios and other service specific identifiers align with the fire service. The core objectives of the program are to reduce the stigma of mental illness while also providing skills to promote psychological wellbeing. The concept of a continuum of mental health ranging from healthy to ill through the stages of mild distress and impairment, and the explanation that any of us can move either way along that scale through our lives without necessarily being considered mentally ill, is used to reduce the stigma of mental health. This concept, adapted from the US Marine Corps, also promotes that however far we move along the continuum towards mental illness, or even if we suffer mental illness, we can always move back along the continuum to good mental health with the appropriate kinds of support. Practical skills are also taught to promote psychological wellbeing such as:

- Goal setting – to help motivate and provide direction, thereby increasing the likelihood of success. Participants are encouraged to write goals down and talk about them.
- Mental rehearsal or visualization – rehearse situations and strategies to anticipate events and prepare for challenges.
- Self-talk – we are always talking to ourselves – the course teaches participants to make the messages they give themselves as positive as possible to increase their ability to be successful. Negative messaging, of course, does the opposite.
- Tactical breathing – in other words, slowing the breathing down and taking deeper, rather than shallow breaths. When in a stressful situation, people tend to take breaths that are shallow and irregular. This tends to increase the physiological symptoms of anxiety. Participants are taught to practice slowing their breathing by concentrating on using the diaphragm.

The program is 4 hours in length, and there is also an 8 hour program for supervisors. We hope that this short program with its' fundamental concepts and practical techniques can better prepare our employees for psychological challenges throughout their lives and also make them more able to face those challenges, whether job related or outside of work. We actually see this as a starting point for building resilience into our people as we know the toll that mental illness takes on individuals as well as the organization. This toll at the extreme

Thoughts on CISM and Resilience from a New Fire Chief (Cont'd)

is the aftermath of a co-worker suicide, but even in less extreme forms can cause significant and costly absences from the workplace along with family discord, reduced ability to perform, and personal loss of morale.

In closing I see one of my greatest responsibilities as Fire Chief is to do everything I can to provide the best supports for psychological wellness to my staff, as most of them on the frontline as firefighters will experience more trauma in a few months than most other people will see in a lifetime. We expect a lot of these people who may now actually be at greater risk from psychological trauma rather than physical illness. The number of suicides I spoke to earlier outstrips traumatic line of duty deaths of firefighters across Canada, which reinforces the need for all of us to pay as much attention to psychological health and safety as we do to the more traditional aspects of employee health and safety.

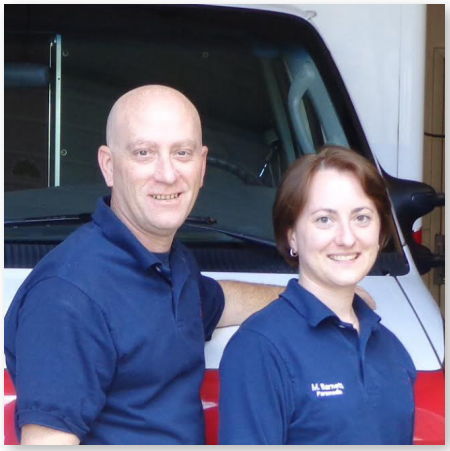
One of Our Own

Continued from page 1

on, what's wrong you old smoker?" then quickly realized that my goofball partner was not goofing around. He picked his head up and looked at me with terror in his eyes, grabbed at his chest, and said his chest was on fire. I ordered this stubborn man to get out to the ambulance and my heart sank when I received no contest.

He collapsed onto the stretcher and pulled off his shirt. I turned on the cardiac monitor and pulled out the leads. They wouldn't stick. His breathing was becoming heavier, his color more grey. I didn't need an EKG to tell me that my partner was quickly slipping from my grasp. I called on the radio for additional help. Gauze pad after gauze pad, sticker after sticker, I finally was able to confirm my worst fear. STEMI. My face couldn't lie. My shaking hands gave it away. I looked at him and said "it's real." He closed his eyes.

It felt like hours, but help arrived. I ordered them to drive priority 1 (most critical) to the hospital that was two miles away. I gave aspirin, applied oxygen, and further sank when I realized that his vital signs were too low for me to administer nitro. I sent the EKG to the ER and called them on the radio to give a heads up. "It's one of ours." The four words that EMS never wants to say and the ER never wants to hear.



A second BP pops up on the monitor and it's significantly lower. His color is greyer, muscle tone weak, and he's staring off into space. The voice in my head says a cuss word I can't repeat as I shake him to make sure he is still alive. He turns his head slowly and makes eye contact—they are begging, pleading "help me, I'm going to die." I crouched down beside him and started an IV. At that very moment I felt the telltale bump in the road that signified that we had arrived at the hospital. How in the world could a 4 minute drive take hours?

We rushed inside with him barely awake, vitals even lower. I was shaking, breathless, and scared out of my mind. There wasn't time for report. We lifted him to the ER stretcher and I lost sight of him as a sea of doctors and nurses surrounded him. The familiar monitor alarms were going off, yelling for drugs. I was pushed out into the hallway unsure if I would ever see him alive again.

I collapsed on the floor and the tears started flowing, my partner, my friend, my family member. What little staff wasn't in the room was with me providing hugs, tissues, and water. Several minutes later he was rushed past me to the cath. lab. I followed. I sat alone in the cath. lab waiting room and started making phone calls. His father was on his way. My boss put our ambulance out of service and was on his way. The minutes took hours to pass. His family arrived and we anxiously waited for news.

Finally, the nurse appeared with a smile on her face! A 99% blockage was stented, his vitals had returned to normal, and he was pain free!

He spent a few days in the hospital

One of Our Own (Cont'd)

and is back to his normal self.

Not me.

His pleading and terrified eyes, grey color, and tombstones on the EKG keep flashing through my mind. My hands shake. My chest hurts. I have palpitations, nausea. Dammit, I did what I was trained to do and it worked! But why do I still hurt? I should be happy that I made a difference! Instead, my stomach twists into knots when people tell me I "saved his life." Each day gets slightly better. A concerned boss, supportive co-workers, and ER nurses have lessened the pain.

I contacted ICISF and they connected me with someone who has been most helpful in relieving my pain.

I am not a hero. I am a nurse and paramedic. Most importantly, I am a family member.

This too shall pass and be just another story in my book.

CISM in the Fire Service

Continued from page 2

[CISM] presence and composition, as well as the prevalence of previous mental illness or suicidal ideations. The survey also provided qualitative data on the perceived effectiveness of CISM programs and perceived career impact of seeking behavioral health treatment.

I hypothesized that firefighter behavioral health problems occur at a higher rate than the public sector. Additionally, to increase the firefighter's ability to cope with traumatic stress, the fire service must do a better job in implementing proven critical incident stress management [CISM] programs. To support or discredit this hypothesis, this research sought to ask four primary research questions: do firefighters experience a higher prevalence of mental illness when compared to the general public; are firefighters unwilling to seek help for behavioral health issues; does the fire service utilize a comprehensive stress management approach or a more focused crisis intervention approach; and is the fire service's stress management protocol effective?

First, understanding the prevalence of PTSD in firefighters is something that is difficult to support with current research. Depending on the criteria and methods used, current research reveals prevalence rates that range from 6.5% to 37% 1, 2, 3. The key factor linking all of these reports is the manner in which the presence of symptoms was assessed. Many of the studies, including mine, asked firefighters to self-report symptoms. While this is seems to be a reliable method for gathering such data, the nuances of the fire service culture must be considered. The reality is that firefighters view mental health issues as a sign of weakness; thus, they are unlikely to report symptoms in any setting.

Regardless of the disparity in fire service behavioral health research, there is a clear problem with behavioral health and suicide in the profession. Most in the profession recognize this; however, there is as much disparity in stress management methods. There is not a general consensus as to what programs work best to manage stress in the profession. My research revealed that 55% of the participants reported having no CISM program in their organization. Of those that reported having a program, the composition varied widely. There were countywide programs, external programs provided by third parties, programs provided by other organizations within the local government structure, and simple debriefings, which indicate CISD programs rather than actual CISM.

The composition of the CISM programs revealed some rather interesting percentages. Only 52% of the participants reported that chief officers or clergy members were a part of the program. Even more perplexing was the finding that only 26% reported the participation of behavioral health specialists, and 17% reported the participation of substance abuse professionals. None of the participants reported their programs included family life or marriage counselors. Finally, 31% reported the programs used a peer support system consisting of other fire service professionals.

The utilization of the programs was revealed to be quite low. Only 23% of the participants reported having ever utilized the CISM program. This is likely related to the perceived effectiveness of the programs. Participants were asked to rate the effectiveness of the program using poor, fair, good, or excellent as choices Thirty-five percent rated the effectiveness as poor, 30% as fair, 25% as good, and 10% as excellent. Obviously, the firefighters examined in this research do not feel confident in their CISM programs' ability to function effectively.

Utilization of the programs was also likely impacted by the perception of comfort in seeking treatment for conditions associated with work-related stress and the perception that treatment could have a negative impact on one's career. Fifty-three percent of the participants reported they were not comfortable seeking treatment for work-related stress. Additionally, 56% of the participants reported they felt as though their career would be negatively impacted

CISM in the Fire Service (Cont'd)

if they sought behavioral health treatment.

Finally, the participants were asked to report if they had ever sought treatment for a behavioral health issue or if they had ever had suicidal ideations. Seventy-five percent of the participants reported they had never sought behavioral health treatment. Similarly, 94% reported they had never had any suicidal ideations. This is in spite of the fact that, when rated on a scale of 1-10, a majority of the participants reported their daily stress levels to be higher than 5.

There are a few things we must address in order to get a handle on the behavioral health situation in the profession. The review of literature and results of this research lead me to offer four recommendations. First, a consistent measurement tool for predicting and identifying PTSD symptoms must be identified and implemented across the fire service. The prediction tool could be used in recruiting and promotional processes as a means of identifying firefighters who are at a greater risk for developing PTSD. This type of evaluation is no different than identifying cardiac risk factors during the annual medical examination. Similar to the medical screening, the prediction measure could reveal the potential to save a firefighter's life before a catastrophic mental health event occurs. Second, a national reporting database should be implemented in the U.S. Fire Service. Just as the National Fire Incident Reporting System [NFIRS] tracks incident data and the Firefighter Near-Miss Reporting System tracks near-miss incidents, a national mental health database could provide valuable data in combatting mental health issues in the fire service. In short, behavioral health issues should be viewed as an occupational injury and tracked accordingly. Third, the fire service should develop a critical incident stress inventory. Such an inventory would facilitate a better understanding of what types of incidents can lead to PTSD symptoms4. Finally, fire service organizations should implement the CISM method in an effort to combat stress in firefighters. Such a program should be a comprehensive approach that integrates multiple tactics in mitigating the effects of CIS5. The program should focus on pre-incident education, peer-support networks, increasing PTG, and decreasing PTSD.

The fire service certainly has a need to further understand the implications the profession has on its members. Efforts to combat the problem are disjointed, and there is a lack of a national agenda on the topic. The fire service must promote further research and implement comprehensive CISM programs in order to understand and combat behavioral health issues in the profession and the epidemic of suicide amongst its personnel. It my hope that this research can serve as a catalyst to further the understanding of PTSD in our nation's bravest.

" To read the complete research article, please visit the ICISF member library"

References

1. Corneil, W., Beaton, R., Murphy, S., Johnson, C., & Pike, K. (1999). Exposure to traumatic incidents and prevalence of posttraumatic stress symptomatology in urban firefighters in two countries. Journal of Occupational Health Psychology, 4(2), 131-141.
2. Del Ben, K. S., Scotti, J. R., Chen, Y., & Fortson B. L. (2006). Prevalence of posttraumatic stress disorder symptoms in firefighters. Work & Stress, 20(1), 37-48.
3. Meyer, E. C., Zimering, R., Daly, E., Knight, J. & Kamholz, B. W. (2012). Predictors of posttraumatic stress disorder and other psychological symptoms in trauma-exposed firefighters. Psychological Services, 9(1), 1-15.
4. Donnelly, E. A. & Bennett, M. (2013). Development of a critical incident stress inventory for the emergency medical services. Traumatology, 20(1), 1-8.
5. Mitchell, J. T. (2004). Crisis intervention and critical incident stress management: A defense of the field. http://www.icisf.org/wp-content/uploads/2013/04/Crisis-Intervention-and-Critical-Incident-Stress-Management-a-defense-of-the-field.pdf

CISM Support for Members Affected by Edmonton's Mass Homicide

Continued from page 2

above made a definite impact on our members' wellness. Applying the basics of CISM, normalizing their individual reactions and reminding them of healthy coping strategies were key. I've always held the strong belief that bringing cops back into their teams after a traumatic event is something that must be done, hence the need for CISM Debriefings. Providing them an opportunity to talk about their shared (and personal) experience, as it relates to their own symptoms and coping

abilities, in front of their peers is an exercise that always amazes me. You can often physically feel the weight lifting from their shoulders as they realize that they are not the only ones having a reaction. It is equally important that the higher-ups support CISM, its processes and what it means to do CISM work, which I can tell you in Edmonton, it clearly is supported.

From these types of events there is always some "take away" on how it can be done better for the next one as well as some things that were done right, either by design or accident. Certainly this event is no different. Some things that I feel were done right was the swift response to the "ground zero" members coming back from the scene, the immediate response from my sworn CISM Team volunteers to drop what they were doing and come to help. As a team we were well organized in terms of obtaining a complete list of all the members, both sworn and non-sworn, that were involved to some degree or another which certainly helped in deploying CISM resources appropriately.

Some things that could have been done better include providing CISM care of the "peripheral members" as well as support units such as Dispatch, Communications, and Forensics should have been done sooner rather than later. At times like these, resources are quickly used up; care must be taken to not burn out your team while trying to provide the best available service to your members. As always, an open and active line of communication helped us keep track of who was doing what and what was left to do.

ICISF Staff Directory

Richard Barton
rbarton@icisf.org
Chief Executive Officer

John Newnan
jnewnan@icisf.org
Director of Development

Victor Welzant, PsyD
welzant@icisf.org
Training & Education Director
LifeNet Co-Editor

Lisa Joubert
lisa@icisf.org
Finance Director
Accounts Payabl
Accounts Receivable

Jeannie Gow, CTR
jgow@icisf.org
Information Specialist

Steven H. Wilson
swilson@icisf.org
IT Manager

Ethan Wilson
ethan@icisf.org
Webmaster
LifeNet Design

George Grimm
hotline@icisf.org
CISM Teams/Hotline Coordinator,
Hotline Records

Michelle Parks
mparks@icisf.org
Membership
CE Program Coordinator,
Certificate of Specialized Training
LifeNet Co-Editor
Online Training Coordinator

Kate Looram
kate@icisf.org
Approved Instructor
Program Coordinator,
A.I. Workbooks,
Certificates & Invoicing

Terri Pazornick
terrip@icisf.org
Education & Training Manager,
Speakers Bureau, Trade Shows
World Congress Manager

Michelle Long
mlong@icisf.org
Conference Coordinator

Michelle Warshauer
Special Projects

Diane Taylor, Ed.D, PMHCNS-BC
Editorial Board

lifenet@icisf.org
Suggestions, comments and/or
inquiries about this publication.

INTERNATIONAL CRITICAL INCIDENT STRESS FOUNDATION, INC.

connecting the crisis response community

www.ICISF.org

International Critical Incident Stress Foundation, Inc.
3290 Pine Orchard Lane, Suite 106
Ellicott City, MD 21042

(410)750-9600