# NENA Standard on 9-1-1 Acute/Traumatic and Chronic Stress Management

NENA Standard on 9-1-1 Acute/Traumatic and Chronic Stress Management

NENA-STA-002
DSC Approval: 03/12/2013
PRC Approval: 05/23/2013
NENA Executive Board Approval: 08/05/2013

Prepared by:
The National Emergency Number Association (NENA) PSAP Operations Committee, 9-1-1 Acute/Traumatic and Chronic Stress Working Group

Published by NENA
Printed in USA

**NENA**
**STANDARD DOCUMENT**
**NOTICE**

This Standard Document (STA) is published by the National Emergency Number Association (NENA) as an information source for the designers, manufacturers, administrators and operators of systems to be utilized for the purpose of processing emergency calls. It is not intended to provide complete design or operation specifications or parameters or to assure the quality of performance for systems that process such equipment or services.

NENA reserves the right to revise this Standard Document for any reason including, but not limited to:

- Conformity with criteria or standards promulgated by various agencies,
- Utilization of advances in the state of the technical arts,
- Or to reflect changes in the design of equipment, network interfaces or services described herein.

This document is an information source for the voluntary use of communication centers. It is not intended to be a complete operational directive.

It is possible that certain advances in technology or changes in governmental regulations will precede these revisions. All NENA documents are subject to change as technology or other influencing factors change. Therefore, this NENA document should not be the only source of information used. NENA recommends that readers contact their 9-1-1 System Service Provider (9-1-1 SSP) representative to ensure compatibility with the 9-1-1 network, and their legal counsel to ensure compliance with current regulations.

Patents may cover the specifications, techniques, or network interface/system characteristics disclosed herein. No license expressed or implied is hereby granted. This document shall not be construed as a suggestion to any manufacturer to modify or change any of its products, nor does this document represent any commitment by NENA or any affiliate thereof to purchase any product whether or not it provides the described characteristics.

This document has been prepared solely for the use of E9-1-1 System Service Providers, network interface and system vendors, participating telephone companies, 9-1-1 Authorities, etc.

By using this document, the user agrees that NENA will have no liability for any consequential, incidental, special, or punitive damages arising from use of the document.

NENA's Committees have developed this document. Recommendations for change to this document may be submitted to:

National Emergency Number Association
1700 Diagonal Rd, Suite 500
Alexandria, VA 22314
800-332-3911
or commleadership@nena.org

**Acknowledgments:**

The National Emergency Number Association (NENA) PSAP Operations Committee, 9-1-1 Acute/Traumatic and Chronic Stress Working Group, developed this document.

NENA recognizes the following industry experts and their employers for their contributions in development of this document.

Executive Board Approval Date: 08/05/2013

| **Members:** | **Company/Agency:** |
|---|---|
| Rick Jones – Operations Issues Director | NENA |
| Dee Ann L. Summersett, ENP – Co-Chair | Tuscola County 9-1-1, MI |
| Jim Marshall, MA, LLP, Co-Chair | 911 Training Institute, 911 Wellness Foundation |
| Dreama Arnett | West Bloomfield Township Police Department, MI |
| Kris Bechtel | Charlotte-Mecklenburg Police Department, NC |
| Sandy Beitel | Ogle County Sheriff's Office |
| Karen Carlucci LCSW | Mental Health Association of New York |
| Susan Carr | City of Plano, TX |
| Karen Chadwick, ENP | Grand Rapids Police Department, MI |
| Quinn Colvin | Benicia, CA |
| Collet Crabill, ENP | Jefferson County, WV |
| John Draper, PhD | National Suicide Prevention Network, NY |
| Jay Dornseif | Priority Dispatch |
| Natalie Duran | Miami Dade Fire Rescue Department, FL |
| Loredonna Elsberry Schwartz, MABC RPL | APCO International |
| Robert Gelbach, PhD | EMDR Humanitarian Assistance Programs |
| Christina Giacomelli | Alameda County CA |
| Sara Gilman MFT | SaraGilman.com |
| Lt. Michael Goold | Sacramento County Sheriff's Department, CA |
| Sheila Hanna-Wiles | APCO Institute |

| | |
|---|---|
| Margie Hatfield, ENP | Hillsdale County 9-1-1, MI |
| Lori Heideman | Wood County Dispatch Center, WI |
| Melinda Hunley | Kern County Fire Department, CA |
| Jim Lanier | Alachua County, FL |
| Sharon Lanier | WhisperWorks Consulting, FL |
| Susan Lewis Simons, MS BCETS DAAETS | Under the Shield |
| Richard McKeon | Substance Abuse and Mental Health Services Administration, MD |
| Ron Meece, ENP | Greenville County, SC |
| Harriet Miller-Brown | State of Michigan |
| Constance Mulgrew | Charlotte-Mecklenburg Police Department, NC |
| Lt. Jan Myers | Oregon Department of Public Safety Standards and Training |
| Rhonda Owens | Eaton County 9-1-1, MI |
| Carlynn Page | National Academies of Emergency Dispatch |
| Heather Pierce | Northern Illinois University (Grad. Student) |
| Joseph Pope | Keller Police Department, TX |
| Leah Rafferty | City of Spearfish, SD |
| H. Reese Butler II | National Hopeline, Network, NC |
| Kimble Richardson, MS, LMHC, LCSW, LMFT, LCAC | St. Vincent Stress Center, Indianapolis, IN |
| Joseph Schillaci | Miami Police Department, FL |
| Doug Showalter, PSDS | California Highway Patrol |
| Lt. Denise Stanley | Decatur Police Department, AL |
| Bonni Stockman | Salt Lake City Department of Airports, UT |
| Jeri Tapper, ENP | Van Buren County, MI |
| Jerry Turk | Powerphone |
| Jennifer Vandenbossche, ENP | South East Regional Emergency Services Authority Communications, MI |

| | |
|---|---|
| Jennifer Vanderstelt | Ottawa County Central Dispatch, MI |
| John White | Institute of HeartMath |
| Kevin Willett | Public Safety Training Consultants &<br>9-1-1 Cares |
| Teresa York | Mission Critical Partners |
| Kelly Zenz | Wood County Dispatch Center, WI |

This working group also thanks Pete Eggimann and Jim Shepard, Development Steering Council Co-Chairs; Roger Hixson, Technical Issues Director; and Ty Wooten, Director of Education and Operational Issues Director for their support and assistance.

# Table of Contents

# 1 Executive Overview

Concern about the impacts of 9-1-1 work-related stress has increased in recent years among the membership of the National Emergency Number Association (NENA). Findings from Roberta Troxell's research released in 2008 indicate that 16.3 percent of 9-1-1 Telecommunicators/Dispatchers may be at risk of Secondary Traumatic Stress Disorder (STSD)[1]. She found that nearly half of 9-1-1 Telecommunicators/Dispatchers in her study reported feelings of intense fear, horror and or helplessness in response to calls involving death or injury to members of field response teams, death or serious injury to children, and interactions with suicidal callers.[2] Such reactions are evidence of exposure to traumatic events as will be discussed later. Implementation of Next Generation 9-1-1 (NG9-1-1) may further increase the risk of incurring STSD.[3] During his 2010 tenure, NENA President Craig Wittington proposed the formation of the NENA Working Group on 9-1-1 Stress. Nearly fifty 9-1-1 professionals, mental health subject matter experts, and 9-1-1 vendors subsequently joined to establish the present document providing an industry wide standard for Public Safety Answering Points (PSAP) defining essential measures for the care and support of 9-1-1 personnel to prevent and manage PSAP work-related stress. This Standard comprehensively addresses the risks posed by psychological stress on the personal health and organizational performance of PSAPs in North America. These risks and the costs of unmanaged stress are high for all 9-1-1 stakeholders—the 9-1-1 Telecommunicator/Dispatcher, the organization of the local PSAP, field responders who rely on dispatch personnel on scene, and for the public who depend on 9-1-1 for emergency service. First, the nature of the problem will be defined, particularly recognizing three classes of stress: 1) *acute traumatic stress* related to the 9-1-1 Telecommunicator/Dispatcher's exposure to tragic call conditions and radio contact with field responders in perceived life-death scenarios; 2) *acute sub-threshold stress* experienced by 9-1-1 Telecommunicators/Dispatchers as they relate to the public, field responders, and other PSAP personnel. While non-traumatic, such commonly occurring events and work conditions still can produce stress and pose health and performance risks. Both these forms of acute stress can lead to Acute Stress Disorder (ASD), Post Traumatic Stress Disorder (PTSD), and the clinical Secondary Traumatic Stress Disorder (STSD), and Compassion Fatigue[4]; and 3) *The chronic stress response* results from long term exposure to ongoing and repeated activation of the acute stress response. It is known to increase the risk of numerous physical diseases that can seriously impair health and performance. In this Standard,

---

[1] Troxell, R., 2008. Doctoral dissertation: *Indirect exposure to the trauma of others: the experiences of 9-1-1 telecommunicators*, University of Illinois at Chicago, 2008. 308 pages. http://gradworks.umi.com/3335425.pdf

[2] Ibid

[3] NG9-1-1 capability is proposed to *"…enable the public to send emergency communications to 9-1-1 Public Safety Answering Points (PSAPs) via text, photos, videos, and data and enhance the information available to PSAPs and first responders for assessing and responding to emergencies"*. Source: Federal Register Volume 76, Number 197 (Wednesday, October 12, 2011), [Proposed Rules], p. 63258. From the Federal Register Online via the Government Printing Office [www.gpo.gov/fdsys/pkg/FR-2011-10-12/pdf/2011-26258.pdf].

[4] STSD and Compassion fatigue are currently not listed in the Diagnostic and Statistical Manual of Mental Disorders.

these and other key terms will be defined to assure an accurate and shared basis for understanding of the 9-1-1 stress problem so that viable solutions can be proposed. Human and organizational implications of failure to address the problem will then be explored, including: health risks, lower employee retention, increased liability related to impaired work performance, and declining morale and attitudes in the workplace. In combination, these potential impacts of unaddressed 9-1-1 stress threaten the PSAP's fulfillment of its mission to provide optimal emergency response to the public.

The Standard is then set forth to prevent and minimize these impacts. This Standard specifies that PSAP Comprehensive Stress Management Programs (CSMP) shall be implemented by PSAPs to include: training in 9-1-1 acute and chronic stress risk management, educational materials and resources on stress management, standardized participation of PSAP personnel in Critical Incidence Stress Management (CISM), and, as needed in relation to such events, active encouragement of PSAP employee use of psychotherapy delivered by qualified trauma therapists and supported by Employee Assistance Programs and/or insurance benefits, and PSAP Peer Support Programs. Finally, the Standard identifies cost benefits of implementing stress programs related to reversals in the above negative trends.

## 1.1 Purpose and Scope

As a Standard, this document provides for essential awareness of the **serious risks** posed by work-related stress on the mental and physical health of 9-1-1 emergency Telecommunicators/Dispatchers in their role as our *first* first responders. It establishes the "best practice" elements of local 9-1-1 comprehensive employee stress management programs and the expectation that such programs will be implemented by PSAPs. The urgency of establishing this standard is heightened by the increases in stress that will likely accompany telecommunication work in Next Generation 911 (NG9-1-1) PSAPs. However, this concern cannot be adequately addressed by this document alone and is therefore beyond its scope. Still, NENA recognizes that a more extensive analysis of the human impacts of NG9-1-1 workplace stress is needed and that a second NENA Working Group devoted to fully addressing this issue may be indicated.

## 1.2 Reason to Implement

The World Health Organization has called workplace stress "the health epidemic of the 21st Century" and estimates that it costs the United States up to 300 billion dollars per year.[5] Unmanaged stress has been found to increase risks of depression[6], cardiovascular disease[7],

[5] Business News Daily: 28, March 2012. See http://www.businessnewsdaily.com/2267-workplace-stress-health-epidemic-perventable-employee-assistance-programs.html.

[6] Stress and Depression. WebMD: http://www.webmd.com/depression/features/stress-depression. Last accessed 12.10.12

[7] R. Sapolsky, *Why Zebras Don't Ulcers: a guide to stress, stress-related diseases, and coping. 3rd Ed. New York: Henry Holt: 2004.*

ovarian cancer[8], fatigue, sleep disorders[9], and greater severity and incidence of viral infection[10]. While no research has yet been conducted on the impacts of stress on job performance in the 911 industry, workplace stress has been linked to dangerous errors in judgment, lack of concentration, and malpractice claims in the medical professions.[11] Emergency 9-1-1 Telecommunicators/Dispatchers endure stress at levels higher than in most professions and now research specifically identifies that the risk of these 9-1-1 professionals experiencing traumatic stress disorders is significantly higher than for the general public. These findings suggest that the PSAP exposes workers to hazardous psychological working conditions that must be addressed just as the National Institute for Occupational Safety and Health (NIOSH) has pursued protection of workers from physically hazardous work materials and conditions[12]. Recognizing the similarly serious impacts of stress in the workplace, NIOSH has also partnered with industry leaders to create model stress reduction programs.[13] Likewise, this document assures that NENA's mission objective to "protect human life[14]" extends to protecting our 9-1-1 workers by establishing an industry wide standard for 9-1-1 Stress Management. Earlier in the history of the 9-1-1 industry, local and national leaders did not have the benefit of knowledge about the health and performance risks posed by 9-1-1 employees' exposure to traumatic and chronic stress. Fortunately, now science has made those risks known. Implementation of this Standard is therefore an ethical duty which can also reduce health risks, PSAP operating expenses and legal liabilities. Adoption of the Standard is also prudent as a preventive measure since the implementation of NG911is predicted to significantly increase 9-1-1 Telecommunicator/Dispatcher's stress.

## 1.3 Benefits

No research has been conducted establishing the benefits of stress management programs *specifically among the 9-1-1 worker population*. Fortunately, however, studies have identified significant benefits of employing stress management in other industries and vocations. In an innovative program originating from a joint venture between NIOSH and Corning, Inc., employees increased their skills to manage work related stress and experienced significant reductions` in stress levels.[15] Similar stress programs have also led to sharp reductions in health care claims among hypertensive employees. Studies also indicate significant impacts of stress

---

**8** E.M. Sternberg, 2011. The Psycho-Neuroendocrine-Immune Connection to Mood Disorders: Does *Stress* Make *Stressed*? - Institute for Functional Medicine, www.functionalmedicine.org/.../TbT_November_2011_Sternb. *Last accessed 12.10.12*

9 J. Maas and R. Robbins. *Sleep for success: Everything you must know about sleep but are too tired to ask.* Authorhouse, Bloomington, IN, 2010.

10 E.M. Sternberg, 2011, Ibid

11 Fact Sheet: workplace stress. Nonprofit Risk Management Center, 2010: http://www.nonprofitrisk.org/tools/workplace-safety/public-sector/topics/ws/stress-ps.htm, last accessed 12.10.12

12 Toward a Typology of Dynamic and Hazardous Work Environments
*NIOSHTIC-2 No. 20021061 (December, 2001)*

13 http://www.cdc.gov/niosh/programs/workorg/partners.html, first accessed November 9, 2011

14 http://www.nena.org/?page=Mission, accessed Novermber 9, 2011

15 http://www.eiconsortium.org/model_programs/stress_management_training.html, accessed 3.16.12

management programs in hospitals including drastic reductions in medication errors and malpractice claims.[16] Other model programs have produced improved attendance records among highway maintenance workers, and reduction in malpractice claims among hospital nurses. The stress reduction program elements set forth in this Standard are consistent with those proven successful in these other settings. Thus, participating PSAPs can expect comparable outcomes benefiting all 9-1-1 stakeholders.

# 2 Introduction

## 2.1 Operations Impacts Summary

PSAP Adoption of this Standard will call for local staff to assume task responsibility for implementation and evaluation of all elements of the CSMP. Such tasks would include procuring CSMP funding, identification and coordination of CSMP resources and facilitating access to related services including Peer Support, Critical Incident Stress Management, local mental health trauma therapists, and other elements of the CSMP (see section 3 for description of CSMP).

## 2.2 Technical Impacts Summary

No new or special technologies are required by this Standard.

## 2.3 Security Impacts Summary

The participation of PSAP personnel in certain services included in the CSMP is to remain confidential. Examples include employee pursuit of Peer Support, and off-site professional counseling (whether provided through Employee Assistance Program). Accordingly, agency procedures will need to be established to assure maintenance such confidentiality.

## 2.4 Document Terminology

The terms "shall", "must", "mandatory", and "required" are used throughout this document to indicate normative requirements and to differentiate from those parameters that are recommendations. Recommendations are identified by the words "should", "may", "desirable" or "preferable".

[16] Fact Sheet: workplace stress. Nonprofit Risk Management Center, 2010: http://www.nonprofitrisk.org/tools/workplace-safety/public-sector/topics/ws/stress-ps.htm, last accessed 12.10.12

## 2.5 Reason for Reissue

NENA reserves the right to modify this document. Upon revision, the reason(s) will be provided in the table below.

| Doc # | Approval Date | Reason For Changes |
|---|---|---|
| NENA-STA-002 | 08/05/2013 | Initial Document |

## 2.6 Recommendation for Additional Development Work

"Is standards development work needed for this topic?" Yes, since the stressors facing 911 professionals operating the PSAP are predicted to increase with the adoption of Next Generation 911 technologies (e.g., texting, real-time video exposure to the public in crisis and the field responders serving them). Additional development by a future working group is anticipated to pursue careful investigation of predictable stress impacts of each specific NG911 technology leading to development of standards that will provide optimal protection of frontline 9-1-1 Telecommunicators/Dispatchers exposed to these NG911 stressors.

## 2.7 Date Compliance

All systems that are associated with the 9-1-1 process shall be designed and engineered to ensure that no detrimental, or other noticeable impact of any kind, will occur as a result of a date/time change up to 30 years subsequent to the manufacture of the system. This shall include embedded application(s), computer-based or any other type application.

To ensure true compliance, the manufacturer shall upon request, provide verifiable test results to an industry acceptable test plan such as Telcordia GR-2945 or equivalent.

## 2.8 Anticipated Timeline

The anticipated timeline for PSAP Implementation of the CSMP will vary depending on the extent to which each PSAP currently deploys elements of the CSMP. For example, PSAPs already implementing Employee Assistance Programs will likely require little additional efforts or time to strengthen or maintain these services. It is anticipated that other CSMP elements described in Section 3 of this Standard can be fully deployed within three to nine months upon adoption. Variations in this timeline will depend on availability of resources. Rural PSAPs within which mental health services are lacking may require additional staff time to identify treatment providers qualified to offer trauma therapy while more metropolitan PSAPs may complete set-up of their CSMPs within as little as 3 months. This timeline assumes rapid assignment of PSAP CSMP oversight to a designated staff member who will oversee its implementation.

## 2.9 Cost Factors

Costs related to PSAP implementation of the 9-1-1 Center CSMP defined in this standard will be incurred by those PSAPs without existing Employee Assistance Programs (EAP) that provide financial coverage for a limited number of counseling sessions. PSAPs with existing EAPs may incur additional costs to secure services from clinicians qualified to treat traumatic stress if existing EAP contractual clinicians are not so qualified. Additional costs may also be expected related to provision to stress management training for staff and staff participation in CISM on a paid-time basis

## 2.10 Cost Recovery Considerations

PSAPs can predict that financial costs of implementing the 9-1-1 CSMP will be offset by cost reductions related to absenteeism, medical and personal leave time, resignations, recruitment efforts, legal liability, and by improved productivity. It is proposed that legislation enabling NG9-1-1 include provision for funding to support 9-1-1 Center CSMPs. In addition, funding of CSMPs may be absorbed by pursuit of grants funded by charitable organizations that recognize the societal contributions of 9-1-1 personnel. Since emerging technologies enabling NG911 capabilities will also place additional stress on PSAP members, industry vendors providing these technologies could consider contributing financially as corporate citizens to support local CSMPs.

## 2.11 Additional Impacts (non cost related)

Beyond those impacts discussed earlier in this NENA document, the information or requirements contained herein are not expected to have operational or technical impacts, based on the analysis of the authoring group.

## 2.12 Intellectual Property Rights Policy

NENA takes no position regarding the validity or scope of any Intellectual Property Rights or other rights that might be claimed to pertain to the implementation or use of the technology described in this document or the extent to which any license under such rights might or might not be available; nor does it represent that it has made any independent effort to identify any such rights.

Consistent with the NENA IPR Policy, available at www.nena.org/ipr, NENA invites any interested party to bring to its attention any copyrights, patents or patent applications, or other proprietary rights that may cover technology that may be required to implement this standard.

Please address the information to:

National Emergency Number Association

1700 Diagonal Rd, Suite 500
Alexandria, VA 22314
800-332-3911
or commleadership@nena.org

## 2.13 Acronyms/Abbreviations, Terms and Definitions

Some acronyms/abbreviations, terms and definitions used in this document may have not yet been included in the master glossary. After initial approval of this document, they will be included. See NENA 00-001 - NENA Master Glossary of 9-1-1 Terminology located on the NENA web site for a complete listing of terms used in NENA documents. All acronyms used in this document are listed below, along with any new or updated terms and definitions.

| **The following Acronyms/Abbreviations are used in this document:** | | |
|---|---|---|
| Acronym | Description | ** N)ew (U)pdate |
| ***CSMP*** | Comprehensive Stress Management Program | [N] |
| ***CISD*** | Critical Incidence Stress Debriefing | [N] |
| ***CISM*** | Critical Incidence Stress Management | [N] |
| ***EAP*** | Employee Assistance Program | [N] |
| ***EBP*** | Evidence Based Psychotherapy | [N] |
| ***EMDR*** | Eye Movement Desensitization and Reprocessing | [N] |
| ***ET*** | Exposure Therapy | [N] |
| ***PTSD*** | Post-Traumatic Stress Disorder | [N] |
| ***SIT*** | Stress Inoculation Training | [N] |
| ***STSD*** | Secondary Traumatic Stress Disorder | [N] |

| **The following Terms and Definitions are used in this document:** | | |
|---|---|---|
| Term | Definition | ** N)ew<br>(U)pdate |
| ***Acute Stress Disorder (ASD)*** | ASD refers to clinically significant (causing significant distress or impairment in social, occupational, or other important areas of functioning) symptoms more than two days but less than one month after exposure to a trauma, as defined above (may progress to PTSD if symptoms last more than one month).[17] | [N] |
| ***Chronic Stress Response*** | Ongoing activation of (or failure to resolve) the stress response. This chronic state can lead to impaired personal functioning and numerous physical diseases and psychological disorders. | [N] |
| ***Compassion Fatigue (CF)*** | This term is often used in mental health as a synonym for Secondary Traumatic Stress (STS, see term listed separately below). However the definition of CF used herein recognizes it as umbrella syndrome that involves both STS and the condition commonly referred to as "burnout". Burnout "...concerns things such as exhaustion, frustration, anger and depression..."[18] This component of Compassion Fatigue emphasizes that the "...caregiver's experience of empathy with those that are served can reach a point where continued exposure to the stressor will overtax the abilities of the individual to effectively manage the stress. Exhaustion ensues."[19] Thus the caregiver, such as a 9-1-1 Telecommunicator/Dispatcher, may cease feeling compassion for those he serves, resulting in impaired work performance and experience diminished quality of life. | [N] |

[17] Source: *DoD/VA Practice Guideline: Management of Post Traumatic Stress*, p. 22. Developed by The Management of Post-Traumatic Stress Working Group, 2010, with support from: The Office of Quality and Performance, VA, Washington, DC & Quality Management Division, United States Army MEDCOM. http://www.healthquality.va.gov/PTSD-FULL-2010c.pdf Accessed 11.12.11

[18] Source: Beth Hudnall Stamm, Director, Institute of Rural Health, Idaho State University, Pocatello, Idaho, USA. See http://proqol.org/Compassion_Fatigue.html, last accessed 10.10.12.

[19] Troxell, R., 2008. Ibid.

| **The following Terms and Definitions are used in this document:** | | |
|---|---|---|
| Term | Definition | ** N)ew<br>(U)pdate |
| ***Critical Incident Stress Management (CISM)*** | CISM is a form of psychological "first aid" and represents a powerful, yet cost-effective approach to crisis response. CISM is a comprehensive, integrative, multicomponent crisis intervention system. Interventions range from pre-crisis, acute crisis, to the post-crisis phase. CISM is also considered comprehensive in that it consists of interventions which may be applied to individuals, small functional groups, large groups, families, organizations, and even communities.<br><br>Interventions include stress management education, stress resistance, and crisis mitigation training for both individuals and organizations. Disasters or large-scale incidents, as well as, school and community disasters may require Rest, Information, and Transition Services (RITS), Crisis Management Briefings ("town meetings"), and staff advisement. Other components include one-on-one crisis intervention/counseling, family crisis intervention, as well as, organizational consultation. Follow-up and referral mechanisms are available for assessment and treatment, if necessary.<br><br>Two interventions especially useful for the first responder community are defusings and debriefings (See definitions below).[20] | [N] |
| ***Defusing*** | A defusing is a 3-phase, structured small group discussion provided within hours of a crisis for purposes of assessment, triaging, and acute symptom mitigation.[21] | [N] |

[20] Mitchell, J. T. & Everly, G.S. (in press). CISM and CISD: Evolution, effects and outcomes. In B. Raphael & J. Wilson (Eds.). Psychological Debriefing. Everly, G.S. & Mitchell, J.T. (1997). Critical Incident Stress Management (CISM): A New Era and Standard of Care in Crisis Intervention . Ellicott City, MD: Chevron. Everly, 0., Flannery, R., & Mitchell, J. (in press). CISM: A review of literature. Aggression and Violent Behavior: A Review Journal.

[21] Ibid. Also, Also Everly, G.S., Boyle, S. & Lating, J. (in press). The effectiveness of psychological debriefings in vicarious trauma: A meta-analysis. Stress Medicine; Everly, G.S. & Mitchell, J.T. (1997). Critical Incident Stress Management (CISM): A New Era and Standard of Care in Crisis Intervention. Ellicott City, MD: Chevron; Flannery, R.B. (1998). The Assaulted Staff Action Program: Coping with the psychological aftermath of violence. Ellicott City, MD: Chevron Publishing; Everly, G.S. &

| **The following Terms and Definitions are used in this document:** | | |
|---|---|---|
| Term | Definition | ** N)ew (U)pdate |
| ***(Critical Incident Stress) Debriefing*** | Debriefing (or "Critical Incident Stress Debriefing", CISD) refers to a 7-phase, structured group discussion, usually provided 1 to 10 days post crisis, and designed to mitigate acute symptoms, assess the need for follow-up and, if possible, provide a sense of post-crisis psychological closure. Debriefings have always been conceived of as one component within a larger functional intervention framework. The effectiveness of CISM programs has been empirically validated through qualitative analyses, controlled investigations, and meta-analyses.[22] | [N] |
| ***Evidence Based Psychotherapy*** | An approach to therapy supported by research findings that provide evidence of its effectiveness.[23] | [N] |
| ***Exposure Therapy*** | One of three evidence based trauma-focused psychotherapies recognized by the Department of Veteran Affairs and the Department of Defense as effective for the treatment of post-traumatic stress disorder.[24] The goals of exposure therapy are to help reduce fear and anxiety and eliminate avoidance behavior. | [N] |

Boyle, S. (1997, April). CISD: A meta-analysis. Paper presented to the 4th World Congress on Stress, Trauma, and Coping in the Emergency Services Professions. Baltimore, MD.

[22] Ibid.

[23] Arlo Pucci, 2005. http://nacbt.org/evidenced-based-therapy.htm. Accessed 11.12.11

[24] Source: *DoD/VA Practice Guideline: Management of Post Traumatic Stress*, pp. 123-125. Developed by The Management of Post-Traumatic Stress Working Group, 2010, with support from: The Office of Quality and Performance, VA, Washington, DC & Quality Management Division, United States Army MEDCOM. http://www.healthquality.va.gov/PTSD-FULL-2010c.pdf Accessed 11.12.11

| **The following Terms and Definitions are used in this document:** | | |
|---|---|---|
| Term | Definition | ** N)ew (U)pdate |
| ***Eye Movement Desensitization and Reprocessing*** | One of three evidence based trauma-focused psychotherapies recognized by the Department of Veteran Affairs and the Department of Defense as effective for the treatment of post-traumatic stress disorder.[25] A comprehensive, integrative psychotherapy approach. [2] EMDR is an information processing therapy and uses an eight phase approach to address the experiential contributors of a wide range of pathologies. It attends to the past experiences that have set the groundwork for pathology, the current situations that trigger dysfunctional emotions, beliefs and sensations, and the positive experience needed to enhance future adaptive behaviors and mental health.[26] | [N] |

[25] Source: *Ibid*, pp. 128-130. Developed by The Management of Post-Traumatic Stress Working Group, 2010, with support from: The Office of Quality and Performance, VA, Washington, DC & Quality Management Division, United States Army MEDCOM. http://www.healthquality.va.gov/PTSD-FULL-2010c.pdf Accessed 11.12.11

[26] Shapiro, F. (2002). EMDR as an Integrative Psychotherapy Approach: Experts of Diverse Orientations Explore the Paradigm Prism. Washington, DC: American Psychological Association Books

| **The following Terms and Definitions are used in this document:** | | |
|---|---|---|
| Term | Definition | ** N)ew (U)pdate |
| ***Post-Traumatic Stress Disorder*** | An official clinical diagnosis of the American Psychiatric Association widely used by mental health professionals to describe and treat the condition of a person who meets the following criteria:<br>• Has been exposed to a traumatic event (see definition of Traumatic Event, page 17)<br>• Experiences several symptoms from each of three symptom clusters:<br>o Intrusive recollections<br>o Avoidant/numbing symptoms<br>o Hyper-arousal symptoms<br>• The above symptoms occur for more than one month (following exposure to the event)<br>• The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. | [N] |
| ***Psychological Trauma*** | A type of damage to the psyche that occurs as a result of a traumatic event. When that trauma leads to posttraumatic stress disorder, changes to brain structure and function occur that impair the person's ability to adequately cope with stress. [27] | [N] |

[27] Source: en.wikipedia.org/wiki/Psychological_trauma

| **The following Terms and Definitions are used in this document:** | | |
|---|---|---|
| Term | Definition | ** N)ew (U)pdate |
| ***Relaxation Response*** | "…the relaxation response is defined as the response that is the opposite of the "fight-or-flight" or stress response. It is characterized by the following:<br>-- decreased metabolism, heart rate, blood pressure, and rate of breathing;<br>-- a decrease or "calming" in brain activity;<br>-- an increase in attention and decision-making functions of the brain; and<br>-- changes in gene activity that are opposite of those associated with stress."[28] | [N] |
| ***Secondary Traumatic Stress (STS) and Secondary Traumatic Stress Disorder (STSD)*** | STS, is referred to herein as a subcomponent of Compassion Fatigue (CF, see earlier definition). It is the specific stress experienced by an individual who has experienced a Traumatic Event (see definition below) involving a threat to the physical integrity of *another person.*…or learning about unexpected or violent death, serious harm…or threat of death or injury experienced by a family member or other close associate..." [29] STS It is "the stress resulting from helping or wanting to help a traumatized person."[30]When this individual's stress results in the symptoms associated with PTSD (see definition above) experts in traumatic stress recognize that condition as STSD. STSD "...is a syndrome of symptoms nearly identical to PTSD (see PTSD definition) except exposure to knowledge about a traumatic event experienced by a significant other is associated with the set of STSD symptoms." [31] [32] | [N] |
| ***Stress*** | Synonym for The Stress Response (see below)[33] | [N] |

[28] H. Benson and W. Proctor. Relaxation Revolution: Enhancing Your Personal Health Through the Science & Genetics of Mind Body Healing. Scribner, 2010, p. 56

[29] 4th version, Text Revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), American Psychiatric Association, 2000, p. 468.

| **The following Terms and Definitions are used in this document:** | | |
|---|---|---|
| Term | Definition | ** N)ew (U)pdate |
| ***(The) Stress Response*** | The series of neurochemical and biological changes in the brain and body orchestrated by the brain to prepare the person for action in response to the perceived psychological demand or threat—the stressor, and to restore biological balance (homeostasis) within and between all systems. In essence, *The Stress Response* refers to the many internal changes that occur to help a person facing a stressor to regain homeostasis [34] | [U] |
| ***Stressor*** | An *external* experience that a person perceives as threatening, leading to activation of the stress response.[35] | [N] |

[30] C. Figley, *Compassion Fatigue: Coping With Secondary Traumatic Stress Disorder In Those Who Treat The Traumatized.* Routledge, 1995, p. 7.

[31] Ibid, p. 8

[32] Unlike family members or others who may experience STSD by observing the person primarily traumatized, 9-1-1 Telecommunicators/Dispatchers are uniquely involved in traumatic events, since while not technically "on scene" they have the professional burden of responsibility to help the individual in crisis nonetheless. Thus, this NENA Working Group recognizes that even as 9-1-1 Telecommunicators/Dispatchers are at risk of traumatic stress disorders whether labeled STSD or PTSD, neither disorder as currently defined fully accounts for 9-1-1 Telecommunicators/Dispatchers' unique exposure to the traumatic events to which they response from the 911 console. This diagnostic limitation reflects upon a bigger limitation in the study of trauma: while PTSD has long been recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), STSD has never not been, nor will it be recognized in the new DSM-V (projected publication in 2013.) The omission of STSD as an "official" DSM diagnosis contradicts the recommendation of Compassion Fatigue pioneer C. Figley and other trauma experts (see C. Figley, 1995). The concept of STSD as one component of Compassion Fatigue put forth by Figley and colleague Beth Hudnall Stamm. Their simultaneous work has greatly advanced our understanding of this syndrome. Stamm's ProQOL tool is used worldwide to screen for Compassion Fatigue and was utilized in the 911 research studies cited in this document by Troxell (2008), and Pearce and Lilly (2012). To learn more about the ProQOL,see http://proqol.org/Compassion_Fatigue.html. Dr. Stamm shares strong concern for the impacts of STSD on 9-1-1 Telecommunicators/Dispatchers (personal correspondence with J. Marshall, 12/10.11 through 9.29.12).

[33]NENA 9-1-1 Stress Work Group member Michael Goold, 2011, recognizes the historical problem with arriving at a definition of stress agreed to by scientists. Thus, the work group has chosen to use the more descriptive synonym *Stress Response* whose definition summarized above is now shared with adequate agreement by stress scientists (see footnote 5).

[34] The concept of stress as "change" is supported by Susan Simon (2011, correspondence with J. Marshall); the current definition of the stress response incorporating this concept of change is from J. Marshall adapted from *G. Mate', When the Body Says No: Understanding the Stress – Disease Connection (New York: John Wiley & Sons, 2003), 34* and from R. Sapolsky, *Why Zebras Don't Ulcers: a guide to stress, stress-related diseases, and coping. 3rd Ed. New York: Henry Holt: 2004.*

[35] Stressors can be single events or ongoing conditions. Each person interprets and reacts differently to experiences based on personal history, personality, and current psychological status. Thus one individual may experience an event as stressful while

| **The following Terms and Definitions are used in this document:** | | |
|---|---|---|
| Term | Definition | ** N)ew (U)pdate |
| ***Stress Inoculation Training*** | SIT is one of three evidence based trauma-focused psychotherapies recognized by the Department of Veteran Affairs and the Department of Defense as effective for the treatment of post-traumatic stress disorder.[36] "…is presented as a tool box or set of skills for managing anxiety and stress (Hembree & Foa, 2000). This treatment was originally developed for the management of anxiety symptoms and adapted for treating women rape trauma survivors. SIT typically consists of education and training of coping skills, including deep muscle relaxation training, breathing control, assertiveness, role playing, covert modeling, thought stopping, positive thinking and self-talk, and in-vivo exposure." | [N] |
| ***Therapeutic Lifestyle Changes*** | TLCs are established regimens assuring recommended practice of exercise, nutrition, sleep, balanced personal investment in work, recreation/personal and family life experience, and spirituality[37] | [N] |

another person does not. However, three factors universally activate stress: uncertainty, lack of information, and loss of control. Source: Mate, G. *When the Body Says No: exploring the stress-disease connection.* 2003, p. 34

[36] Source: *DoD/VA Practice Guideline: Management of Post Traumatic Stress*, pp. 126-127. Developed by The Management of Post-Traumatic Stress Working Group, 2010, with support from: The Office of Quality and Performance, VA, Washington, DC & Quality Management Division, United States Army MEDCOM. http://www.healthquality.va.gov/PTSD-FULL-2010c.pdf Accessed 11.12.11

[37] Walsh, R. Lifestyle and Mental Health. American Psychologist, October 2011, pp. 579-592.

| **The following Terms and Definitions are used in this document:** | | |
|---|---|---|
| Term | Definition | ** N)ew (U)pdate |
| ***Traumatic Event (synonymous to "Trauma"):*** | When a person experiences:<br>"…an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or… a threat to the physical integrity of another person…or learning about unexpected or violent death, serious harm…or threat of death or injury experienced by a family member or other close associate; and when that person has a response to the event that involves "… intense fear, horror or helplessness." [38] | [N] |

[38] 4th version, Text Revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), American Psychiatric Association, 2000, p. 468.

# 3 Description of the 911 Center Comprehensive Stress Management Program (CSMP)

Public Safety Answering Points shall establish Comprehensive Stress Management Programs to include the following elements:

1. **Stress Management Training**, minimum of 8 hours in length for all PSAP personnel, addressing the following topics:
    - The nature of stress, stress disorders (acute/traumatic, chronic), mental and physical health impacts of unmanaged stress
    - Exposure to the above stress types specifically within the PSAP
    - Negative impacts of traditional military denial of traumatic stress on personal health and work performance/importance of supporting and personally embracing proactive stress management
    - Education on coping skills and strategies including Therapeutic Lifestyle Changes (TLC, See T*erms and Definitions* section).
    - Utilization of specific skills activating the Relaxation Response (see *Terms and Definitions* section), including progressive muscle relaxation, diaphragmatic and coherence breathing, and imagery/visualization.
    - Benefits of utilizing other elements of the CSMP cited below
    - Principles and skills for management of emotion and thinking under duress
    - Principles and skills for effective PSAP communication, conflict resolution
2. **On-site PSAP educational materials** and resources about stress related risks, information about available local and online resources to manage stress including traumatic stress disorders, chronic stress and related health problems. Information on role of nutrition, exercise and sleep in prevention of stress disorders and stress-related diseases.
3. PSAP SOP establishing procedures assuring participation of PSAP personnel in **Critical Incidence Stress Management** activities including debriefing sessions when involved in traumatic call events; and as needed in relation to such events. PSAP leaders are also strongly encouraged to promote CISM certification training by at least one PSAP employee to serve as the on-site CISM support person fostering effective use of CISM by PSAP employees. Printed materials and online information should also be provided informing employees about how to access CISM resources, and encouraging appropriate use (e.g, addressing the question: *"When should I ask for help?"*

4. Establish (if not currently provided), educate and encourage employee use of **Employee Assistance Programs (EAPs)** that provide confidential counseling for all PSAP personnel, with funding of initial session(s) to encourage employee use. PSAPs are urged to seek EAP contracts with clinicians familiar with 9-1-1 and who specialize in treatment of traumatic stress disorders (see item 5).
5. **Identify local therapists specializing in treatment of stress and traumatic stress disorders** who utilize evidence based therapies recognized by the Department of Defense and the Veterans Administration to be effective in the treatment of PTSD. These therapies include: Exposure Therapy, EMDR, and/or SIT (see *Terms and Definitions* section for explanation of these therapies). Encourage proactive use of therapy by PSAP personnel.
6. **Establish PSAP Peer Support Programs.** These programs utilize call center staff who are trained to provide confidential emotional support upon request of a PSAP employee without administering advice or solutions. Peer support is not a substitute for professional counseling but serves to defuse stress and staff conflicts while encouraging people to move toward responsible solutions and professional therapy assistance as needed.
7. **Provide "Provide comprehensive, ongoing, certification training** for all PSAP 9-1-1 Telecommunicators/Dispatchers on structured call-taking processes for all emergency call types processed in their PSAP (see NENA Standard for Emergency Call Processing 56-006). 9-1-1 Telecommunicator/Dispatcher training shall also include management of suicidal callers and calls involving persons with serious mental illness[39]
8. **PSAPs are highly encouraged to implement personal health incentivizing programs** to promote employee investment in lifestyle changes and practices shown to prevent mental and physical diseases.

# 4 References

References have been cited as footnotes on the bottom of pages where pertinent information has been discussed to optimize review for readers unfamiliar with mental health terminology and concepts.

# 5 Exhibits

None at present.

[39] This item of the standard offered by J. Marshall, not as co-chair but as working group member. In interest of full disclosure, J. Marshall serves as a vendor offering these services. They are nonetheless critical to prevention of health risks among 9-1-1 Telecommunicators/Dispatchers. Wording of this element is verbatim from a recommendation for revision received in the formal NENA review process (after initial submission of this document).

# 6 Appendix

The 911 Stress Standard Working Group hopes to provide an extensive list of resources which local 911 centers can access on line at no charge, to assist in all phases of implementation of local CSMPs. For more information, contact NENA. Regarding CSMP element 5, a joint non-profit venture is currently underway to create a registry of trauma therapists or dissemination to all North American 911 centers to facilitate accessing these professionals. For updated information on this assistance contact the NENA headquarters.

# 7 Previous Acknowledgments

Not applicable. This is the initial standard.