MEMORANDUM

TO: NFPA Technical Committee on Fire Service Occupational Safety and Health

FROM: Ken Holland, Staff Liaison

DATE: October 27, 2011

SUBJECT: NFPA 15 ROC TC Letter Ballot (A2012)

The ROC letter ballot for NFPA 1500 is attached. The ballot is for formally voting on whether or not you concur with the committee’s actions on the comments. Reasons must accompany all negative and abstention ballots.

Please do not vote negatively because of editorial errors. However, please bring such errors to my attention for action.

Please complete and return your ballot as soon as possible but no later than November 15, 2011. As noted on the ballot form, please return the ballot to Yvonne Smith either via e-mail to ysmith@nfpa.org or via fax to 617-984-7056. You may also mail your ballot to the attention of Yvonne Smith at NFPA, 1 Batterymarch Park, Quincy, MA 02169.

The return of ballots is required by the Regulations Governing Committee Projects.

Attachments: Comments
Letter Ballot
The text and changes published in the ROP need to revert back to the existing text that is found in the current NFPA 150 edition for chapter 12.

Substantiation: The Commonwealth of Massachusetts- and many other states, as well as federal agencies- adopted the International Critical Incident Stress Foundation model as a "standard of care" for the following reasons:

- There simply is no other methodology that can compare to other than CISM as a comprehensive, well-developed, field-tested, and appropriate standard of care in this specialized work with firefighters and first responders;
- CISM provides a structured, systematic approach to the management of a "critical incident" in the fire service from even before notification of an incident (in its "pre-incident education component") to the incident aftermath, which is totally compatible with existing incident command training, and the operational focus of emergency services;
- It is based on "normal reactions of normal firefighters to abnormal events," taking a non-judgmental approach consistent with what has been learned from combat stress and disaster psychology research;
- The goal of all CISM interventions is to lessen the impact of the event, and accelerate normal coping mechanisms, as a subset of the overall field crisis intervention; it does not claim to "cure" anything;
- CISM is not therapy, does not meet the conditions necessary for psychotherapy, does not conflict with ongoing psychotherapeutic work, and makes no therapeutic claims: it is an intervention for a critical incident, just as AA or other well-established self-help groups represent an interventions for other conditions;
- It has almost 30 years of data, studies, articles, surveys, and research behind it, principle among those 55 research efforts which have attempted to capture the essence of why CISM seems to work so well in frontline emergency service units, and why it keeps being requested from the field;
- It is a peer-driven, clinically-guided partnership, which often makes extensive use of emergency services chaplaincy, to address spiritual aspects of the sense of loss and grief which accompany critical incidents;
- CISM is a largely volunteer movement which is not money-driven, and all interventions protect confidentiality;

Criticisms and Contrary Research:

CISM has always been subject to critique and opposition, mostly from the clinical and academic community, beginning with McFarland et al. when in its infancy as CISD. CISM has not only always acknowledged those critiques, it has bent over backward to give them their due, and share them with as much objectivity as possible. The Foundation has acted with integrity in widely publicizing the contrary studies, and restraint in the manner in which it has responded to them. The same cannot always be said of its major detractors, one of whom wrote, in response to the observation that first responders seem to really like CISM: "I like jelly doughnuts, too, but that doesn't mean they're good for me." Another leadership figure at a trauma conference when confronted by a woman from Virginia who was puzzled by the attack on a method which had helped her local rescue squad so much after a flood- responded "addicts like candy laced with morphine, too, but that doesn't mean it 's good for them." A third author, well known in the emergency services field, wrote in a national emergency service magazine, "this work is much too serious to be left to peers," suggesting that those who cannot handle it probably should not be in the service in the first place, and those who legitimately need help should seek individual psychotherapy.

There is no question that CISM can be done poorly. So can any intervention. In the fire service, if the first arriving officer fails to conduct an adequate scene size-up, fails to prepare incoming units and communicate with transmissions and an assessment, fails to effectively attack the fire, fails to establish an adequate water supply, and does not transfer command in person, should we throw out Firefighter I/II training, Company Officer training, and Incident Command? If an ambulance crew facing an offset head-on collision with air-bag deployment and windshield starring walks a patient to the back of the ambulance and has the patient climb in, sizes the collar wrongly, and inadequately secures the patient to a backboard, do we throw out "C-spine precautions"?

Obviously not. These are training issues. CISM, just as with any other operational standard of care, requires training, practice, and accountability.

If we look at sources often cited as damaging to CISM- such as the post-911 "Cochrane Report"- what do we find? The Cochrane report established at least four important criteria for any crisis intervention method purporting to help those in crisis, during and after a multi-casualty, multi-day, collapsed structure, multi-line of duty death event:

An early intervention component. Research identified the primacy of early intervention in disasters (as in combat stress research, immediacy- as well as proximity, and a duty-expectant attitude- turn out to be crucial. CISM begins before a
disaster strikes, in pre-incident training designed to reduce to element of surprise, provide "stress inoculation," and promote resiliency. In trauma work, psychological or medical, "time" does not heal all wounds, time and energy do. Simply allowing time to pass without an action component deepens the risk of infection to an open wound, and deepens the initial psychological shock and disbelief following a disaster;

Multi-Components in the method (no one size fits all; no one method is so all encompassing that it works for all firefighters regardless of degree of exposure. Using the hazmat analogy of a "tied response," CISM size-up includes which units need what interventions, keeping in mind the "bulls eye" theory taught in the assessment part of CISM: similar to the hot, warm, and cool zones in hazmat, not everyone is exposed to the "baddest and the maddest and the saddest," but those who are require significant resources, while those who are not may only need educational and informational approaches);

The Temporal Aspect: "Timing is everything" (CISM teaches that the same intervention performed on day one may not be appropriate six months out from the event. The intervention must be matched not only to the target group, but with what stage of the disaster its members of service are experiencing, and where they are with their own recovery);

The method must be able to be promulgated (no matter how good the method, if it cannot be taught, if there is no body of literature on which to base, if there is no text, or if it cannot be "manualized" as a crisis intervention tool for large numbers of disaster workers, it will not be useful for training and preparation. CISM core courses all have instructional manuals, some on their fourth revisions, and are constantly being upgraded).

No other crisis intervention systematically addresses the needs of first responders in all of the above areas as well as CISM. The "early intervention" aspect is well-addressed through many of its techniques, including demobilizations, crisis management briefings, I: 1's, consultation to command, and chaplaincy compassionate presence. All have many years of growth and development behind them. The "multi-component" aspect speaks for itself. There are fourteen core components to the CISM methodology. The "temporal" aspect is a crucial part of CISM training: every component is taught with an appropriate time frame for its implementation (defusing within on the first 12 hours if possible, etc). Finally, the "manualized" issue is addressed by the comprehensive instructional manuals required for each course, replete with course outlines, goals and objectives, references, and practicum exercises.

"Lack of research"
Since 1983 and the publishing of Jeff Mitchell's original article "When Disaster Strikes" in JEMS magazine, CISM has had a greater body of history, literature, articles, research, and reporting attached to it than any other method specifically designed to reduce the harmful effects of traumatic stress exposure in firefighters and first responders. CISM has been an open book, including 55 major studies available online through the Foundation.

As mentioned before, CISM has accumulated its detractors. One of the principal criticisms has been the dearth of "RCT's" (randomly-controlled trials) studies associated with CISM research, as well as matching for "control" and "experimental" groups on background variables such as socio-economic status, age, ethnicity, and gender, etc. Some of the normal "bells and whistles" expected in social science research- including a large "N" or sample size- have been difficult to provide in CISM studies, although not impossible. The Foundation has acknowledged this, while pointing to those researchers who have been able to address some of these issues, notably Raymond Flannery Jr., former Director of Crisis Services for the Department of Mental Health in Massachusetts, including not only his own Assaulted Staff Action Program," (ASAP), but also his "Meta-Analysis of CISM research;" Atle Dryegrov, Director of the Center for Crisis Psychology in Norway, and research studies conducted with employees exposed to bank robberies in the UK.

Research in CISM poses some unique challenges. It is not easy- at least from an ethical standpoint- to create a "control" group of firefighters who were not offered CISM in the event of a tragedy, or from whom it was withheld, to compare with those who were. But these issues can be dealt with creatively, which the Foundation actively supports. As well, other types of studies beyond those with "RCT's" can be used in social science research, including the "case study" method from the field of social work, which can have equal value in a different way. CISM is not alone in the field of human services in facing this problem, and remains a "work in progress."

Kurt Lewin once wrote, "there's nothing so practical as a good theory." In a disaster where "structure is an antidote to chaos," it is essential to have a multi-component, flexible methodology.

This is not original material; its reference/source is as follows:
Written by a collective group of members of the Massachusetts State Peer Support Network

Committee Meeting Action: Reject
Committee Statement: The committee reviewed existing evidence and revisited such review in light of comments on this subject.

The Committee maintains its original position that the changes adopted by the Committee represent and adequately reflect the current state of scientific and medical evidence and serve the best interest to the fire service and its members.

Current medical and scientific evidence demonstrates that “debriefing” is not effective in treating behavioral health
issues and may be harmful. Given that CISD is closely linked to CISM in nomenclature in many minds, the committee has adopted new language that is more generic and provides a more generalized approach to support members. The language does not preclude the practice of evidence supported interventions in any context, but will no longer suggest a specific model or format for delivery of such services.

The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees’ position has been supported through consensus by the National Center for PTSD, NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA, NAEMSP, and NAFTD.
Members that operate on roadway incidents should be provided with garments that ensure proper conspicuity enhancement consistent with the requirements in the Manual on Uniform Traffic Control Devices, 2009 Edition, §6D.03, Worker Safety Considerations, reflectivity such as a highly retro-reflective vest (strong yellow, green, and orange).

Include in the reference section the FHWA MUTCD document:

2.3.3 U.S. Government Publications.


NIOSH Standard for Chemical, Biological, Radiological, and Nuclear (CBRN) Full Facepiece Air Purifying Respirator (APR), March 2003.

NIOSH Standard for Chemical, Biological, Radiological, and Nuclear (CBRN) Open Circuit Self-Contained Breathing Apparatus (SCBA), December 2001.


Substantiation: The committee may wish to be familiar with the following recent peer-reviewed research publications which provide support for the committee's position in revised §8.7.10* with respect to members' use of high visibility clothing and materials:

(1) NFPA 1971 turnout coats in the FDNY pattern perform equivalently in both daytime and nighttime conspicuity to ANSI/ISEA 107 Class 2 vests and ANSI/ISEA 207 vests:


(2) The most common high visibility materials used on NFPA 1971 turnouts were shown to retain approximately 300% of minimum required nighttime performance even as the gear was retired after ten years in the field:


(3) Patterns of high visibility materials, such as that specified on 1971 turnout gear ensembles with bands placed on the ends of the arms and legs, perform superior to designs which restrict placement of visibility material to the torso only, such as ANSI vests, due to “biomotion” visual cues:


The accepted committee proposal 1500-80 Log #CP19 adjusting §8.7.10* results in text that is consistent with current science but not explicit regarding the current regulatory environment. Reference to recent U.S. Federal regulations concerning the use of high visibility clothing by firefighters and other emergency and incident responders when operating on or near public roadways should be included in NFPA 1500 for completeness and consistency. The obvious place for this update is in the annex material supporting revised §8.7.10*.

Updated text in the supporting annex section including the reference to the MUTCD regulation relevant to emergency and incident responders is respectfully offered in this comment.

Note: Supporting material is available for review at NFPA Headquarters.

Committee Meeting Action: Accept in Part

Revise text to read as follows:

Members that operate on roadway incidents should be provided with garments that ensure proper conspicuity enhancement consistent with the requirements in the Manual on Uniform Traffic Control Devices, 2009 Edition, §6D.03, Worker Safety Considerations.

Include in the reference section the FHWA MUTCD document:

Committee Statement: The committee agrees with the submitters comment to re-introduce this modified text back into the annex of the document, that was deleted at the ROP stage as noted by 1500-101 (Log #CP20). The committee did not include however the submitters reference to the United States due to the possible international use of this document.
8.2 Communications.

8.2.1 The fire department shall establish and ensure the maintenance of a fire dispatch and incident communications system that meets the requirements of NFPA 1561 and NFPA 1221, *Standard for the Installation, Maintenance, and Use of Emergency Services Communications Systems*.

8.2.2* The fire department standard operating procedures shall provide direction in the use of clear text radio messages for emergency incidents.

8.2.2.1 The standard operating procedures shall use “emergency traffic” as a designator to clear the radio traffic for emergency affecting the incident.

8.2.2.2 This “emergency traffic” shall be permitted to be declared by the incident commander, tactical level management component supervisor, or member in trouble or subjected to emergency conditions. Any member who becomes aware of an emergency affecting the incident.

8.2.3* When a member has declared “emergency traffic,” that person shall use clear text to identify the type of emergency, change in conditions, or tactical operations.

8.2.3.1 The member who has declared the “emergency traffic” shall conclude the “emergency traffic” message by transmitting “all clear, resume radio traffic” to end the emergency situation or to re-open the radio channels to communication after announcing the emergency message.

8.2.3.2 The standard operating procedures shall use “Mayday” as a designator to identify when a member is in a life threatening situation and in need of immediate assistance.

8.2.3.3 This “Mayday” shall be permitted to be declared by any member who is in or who becomes aware of a member who is in a life threatening situation and in need of immediate assistance.

8.2.3.4 The incident commander shall conclude the “Mayday” by transmitting “Mayday cleared, resume normal radio traffic.”

8.2.4* The fire department communications center shall start an incident clock when the first arriving unit is on-scene of a working structure fire or hazardous materials incident, or when other conditions appear to be time sensitive or dangerous.

8.2.4.1* The dispatch center shall notify the incident commander at every 10-minute increment with the time that resources have been on the incident until the fire is knocked down or the incident becomes static.

8.2.4.2 The incident commander shall be permitted to cancel the incident clock notification through the fire department communications center based on the incident conditions.

A.8.2.2 The intent of the use of “clear text” for radio communications is to reduce confusion at incidents, particularly where multiple agencies are operating at the same incident.

A.8.2.3 Examples of emergency conditions could be “fire fighter down,” “fire fighter missing,” “fire fighter trapped,” “officer needs assistance,” “evacuate the building/area,” “wind shift from the north to south,” “change from offensive to defensive operations,” “fire fighter trapped on the first floor.” The term *Mayday* should not be used for fireground communications in that it could cause confusion with the term used for aeronautical and nautical emergencies.

Examples of situations where the term “Mayday” should be used include a lost or missing member, an SCBA malfunction or loss of air, member seriously injured or incapacitated, member trapped or entangled, or any life threatening situation that cannot be immediately resolved.

When a firefighter experiences a life-threatening situation he/she must quickly and efficiently be able to take the steps necessary to survive and alert rescuers. This is the time where an individual firefighter will be tested on his/her knowledge of self-survival techniques. Paramount to surviving such an experience is being able to communicate the emergency to rescuers. The terms used to communicate these needs must be chosen carefully. The terms used must be easily understood over the radio in times when operational noise is high. The terms used must also be recognizable as an emergency call for assistance by those on the incident. All persons, regardless of language accent, must easily be able to annunciate the terms used. And finally, the terms used must be short with 2 syllables maximum to allow for a simple single inflexion of the voice to recognize the term.

MAYDAY satisfies all of the above demands for a term that can be used to communicate a firefighter’s need for immediate assistance. MAYDAY is approved for fire service use by the National Search and Rescue Committee, and is currently being used by most fire departments in the United States. Most importantly, MAYDAY is easily remembered.
and understood over the radio when operational noise challenges radio communications.

The concern over MAYDAY causing confusion with aeronautical and nautical emergencies is unfounded. In April of 2002 Dr. Burton A. Clark, EFO, CFO, Management Science Program Chair at the National Fire Academy, and Operations Chief for DHS/FEMA during national disasters wrote to Rear Admiral Ken Venuto (USCG), Chairman of the National Search and Rescue Committee requesting clarification on the use of MAYDAY. In August of 2002 Captain Steve Sawyer (USCG) returned a letter to Dr. Clark stating:

Your recent letter inquired about use by fire departments of the term MAYDAY over ground fire radios when the life of a firefighter is in danger.

Use of MAYDAY under such circumstances is permissible under U.S. law and regulations. The radio frequencies concerned are different from the aeronautical and maritime frequencies, so use of the term should not cause confusion. Further, any effective means of calling for help is authorized under both national and international radio regulations for true distress situations.

Within the letter Captain Sawyer gives further insight on the appropriate use of MAYDAY. On page 2 of the letter it states:

MAYDAY is recognized nationally and internationally as a signal meaning life is in danger and immediate assistance is required, although federal regulations only mention its use for ship aircraft.

The above guidance is based on review of the regulations and consultation with experts of the Cost Guard, FCC, International Civil Aviation Organization and others.

We trust that this explanation will help not only for your local training and operations; you may also find it useful seeking to update relevant guidance in NFPA or other standards as appropriate.

In addition to the “emergency traffic” and MAYDAY, the fire department can use additional signals such as an air horn signal for members to evacuate as part of their standard operating procedures. Some fire departments have developed an evacuation signal that consists of repeated short blasts of apparatus air horns. The sequence of air horn blasts should not exceed 10 seconds in length, followed by a 10-second period of silence, and it is done three times (total air horn evacuation signal including periods of silence lasts 50 seconds). When this evacuation signal is used, the incident commander should designate specific apparatus to sound the evacuation signal using air horns. The apparatus used should not be in close proximity to the command post, if possible, thus reducing the chance of missing any radio messages. During fire fighter rescue operations, the incident commander should consider implementing the following:

1. Requesting additional resources
2. Including a medical component
3. Utilizing staging for resources
4. Committing the RIC team from standby mode to deployment
5. Changing from strategic plan to a high-priority rescue operation
6. Initiating a PAR (personnel accountability report)
7. Withdrawing companies from the affected area
8. Assigning a rescue officer
9. Assigning a safety officer
10. Assigning a backup rapid intervention crew/company
11. Assigning an advanced life support (ALS) or basic life support (BLS) company
12. Requesting additional command level officers
13. Requesting specialized equipment
14. Ensuring that dispatch is monitoring all radio channels
15. Opening appropriate doors to facilitate egress and access
16. Requesting additional vertical/horizontal ventilation
17. Providing lighting at doorways, especially at points of entry

Substantiation: “Emergency Traffic” has been used in the fire service by personnel to gain radio frequency priority for the purpose of announcing and managing critical information during operations. For the last several years the use of the term “Mayday” has increased in common usage throughout the nation. The U.S. Fire Administration publishes a mayday training program, available free to all fire departments. The program provides guidelines to implement comprehensive mayday procedures, and training for use of mayday.

Mayday is a term recognized nationally and internationally as a signal of distress requiring immediate assistance. Incorporating mayday into this standard will codify mayday as accepted fire service terminology.

NFPA 1500 currently states that the term mayday should not be used for fireground communications in that it could cause confusion with the term used for aeronautical and nautical emergencies.

This contradicts a letter received by the U.S. Fire Administration from a U.S. Coast Guard Captain assigned as the Alternate Chair of the National Search & Rescue Committee (NSRC), which has jurisdiction over the use of mayday. The letter specifically states use of mayday by the fire service is permissible under U.S. law and regulations. “The radio
frequencies concerned are different from the aeronautical and maritime frequencies, so use of the term should not cause confusion. Further, any effective means of calling for help is authorized under other national and international radio regulations for true distress situations. The U.S. has taken no action to preclude use of the word Mayday by endangered fire fighters.” Prior to writing the letter, the NSRC consulted “with experts of the Coast Guard, FCC, International Civil Aviation Organization, and others.”

Mayday does not replace the term emergency traffic. Mayday is a sub-component of emergency traffic. Where emergency traffic is generic to many types of critical information that may need priority, mayday is specific to a fire fighter in distress. The primary goal for this revision is to improve fire fighter safety through standardization of methodology already in use.

Committee Meeting Action: Accept
Committee Statement: The technical committee recognizes that this material is “new material” as the concept of “MAYDAY” was not addressed during the ROP phase, however the committee has chosen to act on it for two reasons. The first one being that while reviewing this public comment the committee realized that A.8.2.3 of 1500 does not correlate with NFPA 1561, A.6.3.3. therefore creating a correlation issue within two documents within the same project. The Committee accepts this comment as it brings the two documents into correlation. The committee also felt that this issue was of dire concern and that without having this new requirement placed in the document many more fire fighters could potentially lose their life. In an effort to reduce as well as recognizing the importance of fire fighter injury and death, the committee believes this new material should be added at this time through this public comment.
Suggested additions to the NFPA 1500 Committee’s recent changes for Chapter 11:

Chapter 11

11.1 Behavioral Health Program for Optimum Performance and Wellness

11.1.1 The fire department shall provide access to a behavioral health program for its members, fire personnel and their immediate families.

11.1.1.1 The behavioral health assistance program for optimum performance shall include the capability to provide assessment, basic counseling, and stress crisis interventions for critical incident stress, guidance, consultation, behavioral health and wellness education, mediation, and referrals for life problems that adversely affect firefighter work performance.

11.1.2 The behavioral health program shall, when clinically indicated, refer members or their immediate families for appropriate clinical and specialty from providers equipped to deliver evidence based treatment consistent with current best practices and standard of care. When necessary, refer a member or their family members to a certified or licensed mental health provider.

11.1.3 The fire department shall adopt and follow clear, written policies regarding alcoholism, substance abuse, and other behavioral conditions that may adversely affect performance and/or fitness for duty, and make referrals to the Director of Behavioral Health Services for continued care.

11.1.3.1 When fitness for duty is in question, such fitness shall be evaluated and determined consistent with Section 10.7. Fitness for Duty Evaluations above by the occupational physician and the certified or licensed clinical director of behavioral health services.

11.1.4 The fire department behavioral health program shall adopt and follow clear, written policies consistent with applicable certification boards or state statues, regulations, and standards respecting records, confidentiality, duty to warn, data gathering and reporting, and protection and release of privileged information related to its behavioral health program release of information, and consent to treat.

11.1.4.1 The policy will abide by state statute pertaining to certified or licensed behavioral health providers and These policies shall identify the appropriate content to be obtained on a release of information form, as to whom and under what conditions information can be released, for what purpose, and for what time frame. Use, if any, can be made of these records for purposes of research, program evaluation, and quality assurance.

11.1.5 Member records maintained by a certified or licensed behavioral health program provider shall not become a part of the member’s personnel file and shall contain release of information and consent to treat forms.

11.1.5.1 The Clinical Director or Behavioral Health shall not be required to document or keep records of non-therapeutic encounters such as, consultations, guidance on stressors and wellness, interventions, mediations, behavioral health and wellness education or referrals.

11.1.6 The program should be systematically reviewed on a regular basis to provide an objective evaluation of operation and performance. Program evaluation must adhere to strict confidentiality guidelines where personal issues and the participant cannot be identifiable.

11.2 Wellness Program

11.2.1 The wellness program shall provide prevention strategies and health promotion activities related to identified risk factors for firefighter health and safety to be overseen by the Health Fitness Coordinator and the Clinical Director of Behavioral Health to provide physical fitness and mental fitness.

A.11.2.1 Components of a prevention and health promotion program include cardiac risk reduction, smoking/tobacco cessation, blood pressure regulation, strength and aerobic physical fitness training, nutrition, stress management, diabetes prevention through blood sugar monitoring after critical incidents, metabolic syndrome prevention, with weight management or control, and should provide education (Health and Fitness Coordinator) and counseling (from Clinical Director), for the purpose of preventing health problems and enhancing overall well-being.

11.2.2 The wellness program shall, wherever possible, employ prevention strategies and programs supported by peer reviewed published research, for which published empirical research supports their safety and efficacy.

11.2.2.1 The fire department shall provide a smoking/tobacco cessation program.

Substantiation:

1. To add “for Optimum Performance” to the title is more positive and is the ultimate goal for behavioral health and wellness.

11.1 Behavioral Health Program for Optimum Performance and Wellness.
2. This reads better.

11.1.1 The fire department shall provide access to a behavioral health program for its members fire personnel and their immediate family family members.

3. Behavioral Health Program is different from an Employee Assistance Program. Additionally, firefighters don’t seem to like the word crises for themselves and use it for civilians. For example, firefighters respond to other peoples crisis and if it is critical, it becomes a critical incident for them possibly creating stress, thus the terminology critical incident stress and medication should also be included in this section for team performance and healthy crew relations. Basic services not basic counseling should be referred to as consultation, education, and guidance written in 11.1.5.1.

11.1.1.1 The behavioral health assistance program for optimum performance shall include the capability to provide assessment, basic counseling, and crisis stress interventions for critical incident stress, guidance, consultation, behavioral health and wellness education, mediation, and referrals. Members of the behavioral health program shall be prescribed and referred to the appropriate clinical and specialty from providers equipped to deliver evidence based treatment consistent with current best practices and standard of care. Members of the behavioral health program shall be permitted to determine their personal treatment needs and shall be able to choose from the list of approved providers. Members of the behavioral health program shall consult with their certified or licensed behavioral health provider at least monthly or more frequently as necessary.

4. A certified or licensed mental health professional at best should be trained and certified in a theory that has components of evidence based treatment and understand ethical standards of care or they will get their certified or licensed revoked. Certification and licensing boards oversee these types of credentials. Components of psychological and counseling theories have been researched, but not all have, but are taught in credentialed academic institutions. Additionally, the literature shows that most individuals get better on their own with social support, thus showing the importance of peer support teams. Changing thoughts from negative to positive to reduce depression, as in the Beck Study (Beck. A. T. (1991). Cognitive therapy a 30 year retrospective. American Psychologist. 45(4), 368-375) is reflected in most theories, as well as, coping evidenced based research proving reappraisal from threat/harm or loss to meeting the challenge to increase performance. Therefore, the term certified or licensed defines the given! 11.1.2 The behavioral health program shall, when clinically indicated, refer members or their immediate families for appropriate clinical and specialty from providers equipped to deliver evidence based treatment consistent with current best practices and standard of care: when necessary, refer a member or their family members to a certified or licensed mental health provider.

5. We need to do all we can to provide treatment for our fire personnel, since alcohol and substance abuse is linked to critical incident stress. Sometimes is an avoidance coping method to escape critical incident stress and to have fun. This can best be monitored by well trained peer support team members.

11.1.3 The fire department shall adopt and follow clear, written policies regarding alcoholism, substance abuse, and other behavioral conditions that may adversely affect performance and/or fitness for duty and make referrals to the Director of Behavioral Health Services for continued care. The behavioral health program will follow these statues not the fire department.

6. The behavioral health director and occupational physician can come up with the best plan of continued care, when working together that can help return the member to their optimum levels of performance.

11.1.3.1 When fitness for duty is in question, such fitness shall be evaluated and determined consistent with Section 10.7. Fitness for Duty Evaluations above by the occupational physician and the certified or licensed clinical director of behavioral health services.

7. The behavioral health program will follow these statues not the fire department.

11.1.4 The fire department behavioral health program shall adopt and follow clear, written policies consistent with applicable certification boards and state statues, regulations, and standards respecting records, confidentiality, duty to warn, data gathering and reporting, and protection and release of privileged information related to its behavioral health program release of information, and consent to treat.

8. Information cannot be released for research, if there are not tight controls protecting identity and situations linking the information back to the firefighter. Program evaluation may also be a breach of confidentially. This would have to be in accordance with each state and their licensing board. This is a very sensitive matter and can become a legal situation, if not written carefully. Release of information and Consent to Treat forms are a national standard and reflected in certification regulatory boards and state statue for certified or licensed behavioral health providers and should be stated in policy. 11.1.4.1 The policy will abide by state statue pertaining to certified or licensed behavioral health providers and these policies shall identify the appropriate content to be obtained on a release of information form, as to whom and under what conditions information can be released, for what purpose, and for what time frame. Use, if any, can be made of records for purposes of research, program evaluation, and quality assurance.

9. Additionally, the release of information forms and consent to treat forms should be held in behavioral health professionals files for confidentiality purposes and not personnel files.

11.1.5 Member records maintained by a certified or licensed behavioral health program provider shall not become a part of the member’s personnel file and shall contain release of information and consent to treat forms.

10. Most organizational behavioral health providers and school counselors are not required to document non-therapeutic encounters. This should be reflected in the NFPA 1500 Chapter 11.
11.1.5.1 The Clinical Director of Behavioral Health shall not be required to document or keep records of non-therapeutic encounters such as, consultations, guidance on stressors and wellness, interventions, mediations, behavioral health and wellness education or referrals.

11. The program evaluation can be a breach of confidentiality, if the surveying questions and methods are not tightly controlled linking information to the participant. State licensing boards have complaint policies and oversee provider competencies. This is beyond the scope of the NFPA 1500.

11.1.6 The program should be systematically reviewed on a regular basis to provide an objective evaluation of operation and performance. Program evaluation must adhere to strict confidentiality guidelines where personal issues and the participant cannot be identifiable.

11.2 Wellness Program

1. The Health Fitness Coordinator needs to work closely with the Clinical Behavioral Health provider, since both are specialized fields.

11.2.1 The wellness program shall provide prevention strategies and health promotion activities related to identified risk factors for firefighter health and safety to be overseen by the Health Fitness Coordinator for physical fitness and the Clinical Director of Behavioral Health for mental fitness.

2. Counseling by state statute is to be performed by a certified or licensed professional mental health provider, who has had supervised clinical counseling practicums and internships.

A.11.2.1 Components of a prevention and health promotion program include cardiac risk reduction, smoking/tobacco cessation, blood pressure regulation, strength and aerobic physical fitness training, nutrition, stress management, diabetes prevention through blood sugar monitoring after critical incidents, metabolic syndrome prevention, with weight management or control, and should provide education (Health and Fitness Coordinator) and counseling (from Clinical Director), for the purpose of preventing health problems, enhancing overall well-being and increasing peak performance.

3. Certified Physical Fitness Coordinators, prior to being certified, have to prove competencies in the field and pass credentialing exams.

11.2.2 The wellness program shall should, wherever possible, employ prevention strategies and programs supported by peer reviewed published research, for which published empirical research supports their safety and efficacy.

11.2.2.1 The fire department shall provide a smoking/tobacco use cessation program.

This is not original material; its reference/source is as follows:

References to other research/including my own.

Committee Meeting Action: Reject

Committee Statement: The committee believes that the text in the ROP addresses this subject appropriately however the committee did conduct a careful and thorough review of all comments and substantiation provided.
James D. Herbert, Drexel University

I am writing in support of the proposed changes to the above referenced document (particularly chapters 11 and 12, and associated materials).

Given that firefighters and other first responders are all too frequently exposed to potentially traumatizing events, it is imperative that they receive the most effective and appropriate possible interventions. Moreover, consistent with the principles of evidence-based medicine and evidence-based behavioral health practices, intervention guidelines should be determined by the best available scientific evidence, rather than by political considerations or clinical lore.

Unfortunately, treatments for post-traumatic reactions have often fallen short of this standard. A growing body of research reveals that individuals in the immediate aftermath of traumatic events tend to be vulnerable to authoritative suggestion, whether this consist of messages of resilience or of expected morbidity. My colleagues and I have conducted studies documenting such effects in groups as diverse an indigent African populations (e.g., Yeomans et al., 2008; 2010). We have also documented historical evidence consistent with this effect (Herbert & Sageman, 2004; Herbert & Forman, 2010), and a number of highly respected authorities have found similar results. Unfortunately, certain popular post-traumatic behavioral interventions, in particular certain so-called “debriefing” programs, although well intentioned, foster morbid expectations regarding the likelihood of developing psychopathology. Not surprisingly, research has shown that these interventions can have paradoxical effects, actually increasing the likelihood of subsequent psychopathology. As a result, the scientific community has now achieved consensus that such debriefing programs are potentially harmful, and are not recommended (Herbert & Forman, 2006).

I commend the National Fire Protection Association for bringing its practice guidelines in line with current scientific thinking on best practices for first responders, and I strongly recommend acceptance of the proposed changes. If I may provide any further information, please feel free to contact me.

References


Kenneth J. Ruggiero, Medical University of South Carolina

1500-85, 1500-86, 1500-103, 1500-104

I wish to express my support for the proposed changes to chapters 11, and 12, as well as the annexes to these chapters as adopted by the Technical Committee. Our team of licensed practitioners and investigators at the National Crime Victims Research and Treatment Center has served an integral role in collaboration with the National Fallen Firefighters Foundation in addressing firefighters' mental health needs in our community. Much of this work was initiated in response to the Charleston Sofa Super Store fire that occurred in Charleston on June 18, 2007, resulting in the deaths of nine firefighters. Our group is therefore very familiar with the state of the literature and the needs of firefighters who encounter significant occupational stressors.

I am also principal investigator for a provider-training grant funded by Department of Homeland Security (EMW-2010-FP-01518) entitled Bringing Behavioral Health Services to Firefighters. In this grant, we are developing a provider training resource that will support training of mental health practitioners in best practice interventions for firefighters who have encountered occupational stressors. The revised text in chapters 11, 12, and annexes, is fully consistent with the state of the literature as well as our view that Critical Incident Stress Debriefing has not been shown to be effective in controlled study and may result in adverse outcomes for some cases. The state of the field is such that there are now appropriate alternatives to recommend. It is essential that we deliver the best care possible when called upon to do so and that there is wide recognition of interventions that are ineffective or potentially harmful. The revised text endorsed by the Technical Committee reflects this, and is an important step in the right direction.

Submitter: Kenneth J. Ruggiero, Medical University of South Carolina
Comment on Proposal No: 1500-85, 1500-86, 1500-103, 1500-104
Recommendation: I wish to express my support for the proposed changes to chapters 11, and 12, as well as the annexes to these chapters as adopted by the Technical Committee. Our team of licensed practitioners and investigators at the National Crime Victims Research and Treatment Center has served an integral role in collaboration with the National Fallen Firefighters Foundation in addressing firefighters’ mental health needs in our community. Much of this work was initiated in response to the Charleston Sofa Super Store fire that occurred in Charleston on June 18, 2007, resulting in the deaths of nine firefighters. Our group is therefore very familiar with the state of the literature and the needs of firefighters who encounter significant occupational stressors.

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Committee Meeting Action: Reject
Committee Statement: Submitter does not provide any textual changes for the committee to consider. The committee reviewed existing evidence and revisited such review in light of comments on this subject.

The Committee maintains its original position that the changes adopted by the Committee represent and adequately reflect the current state of scientific and medical evidence and serve the best interest to the fire service and its members.

Current medical and scientific evidence demonstrates that “debriefing” is not effective in treating behavioral health issues and may be harmful. Given that CISD is closely linked to CISM in nomenclature in many minds, the committee has adopted new language that is more generic and provides a more generalized approach to support members. The language does not preclude the practice of evidence supported interventions in any context, but will no longer suggest a specific model or format for delivery of such services.

The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees’ position has been supported through consensus by the National Center for PTSD. NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA, NAEMSP, and NAFTD.

Printed on 10/25/2011
Submitter: Richard J. McNally, Harvard University
Comment on Proposal No: 1500-85, 1500-86, 1500-103, 1500-104
Recommendation: I am writing in strong support of the proposed changes to the chapters and annex noted above as adopted by Technical Committee in ROP ballot reported on April 5, 2011.
Substantiation: Within the past decade, controlled studies have shown that psychological debriefing, exemplified by Critical Incident Stress Debriefing, does not reduce posttraumatic morbidity relative to no intervention at all. That is, people exposed to highly stressful events who receive debriefing do not experience fewer stress symptoms than do those who do not receive debriefing. Indeed, some of the methodologically strongest studies indicate that debriefing actually impedes natural recovery from exposure to traumatic stressors (For a comprehensive review, see McNally, Bryant, & Ehlers, 2003, Psychological Science in the Public Interest). Debriefing, especially mandatory debriefing, should cease. I am encouraged that NFPA guidelines are finally coming into line with what the science says about debriefing. Fire service professionals deserve evidence-based interventions.
Note: Supporting material is available for review at NFPA Headquarters.
Committee Meeting Action: Reject
Committee Statement: Submitter does not provide any textual changes for the committee to consider. The committee reviewed existing evidence and revisited such review in light of comments on this subject.
The Committee maintains its original position that the changes adopted by the Committee represent and adequately reflect the current state of scientific and medical evidence and serve the best interest to the fire service and its members.
Current medical and scientific evidence demonstrates that “debriefing” is not effective in treating behavioral health issues and may be harmful. Given that CISD is closely linked to CISM in nomenclature in many minds, the committee has adopted new language that is more generic and provides a more generalized approach to support members. The language does not preclude the practice of evidence supported interventions in any context, but will no longer suggest a specific model or format for delivery of such services.
The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees’ position has been supported through consensus by the National Center for PTSD. NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA, NAEMSP, and NAFTD.
1500-8  Log #16  (Chapter 11, 12, and Annex A)  Final Action: Reject

Submitter: Ron Acierno, Medical University of South Carolina
Comment on Proposal No:  1500-85, 1500-86, 1500-103, 1500-104
Recommendation:  (Supports proposed changes to chapters and annex noted above as adopted by Technical Committee in ROP ballot reported April 5, 2011)
Substantiation:  I am a clinical researcher in the area of post disaster and post combat mental health. The aforementioned changes are supported by the research literature and are in keeping with the scientific state of the art. It is essential that these changes be made, as they are the ones supported by the research we have been conducting at the National Crime Victims Research and Treatment Center for the past 15 years.

Committee Meeting Action:  Reject
Committee Statement:  Submitter does not provide any textual changes for the committee to consider. The committee reviewed existing evidence and revisited such review in light of comments on this subject.

The Committee maintains its original position that the changes adopted by the Committee represent and adequately reflect the current state of scientific and medical evidence and serve the best interest to the fire service and its members.

Current medical and scientific evidence demonstrates that “debriefing” is not effective in treating behavioral health issues and may be harmful. Given that CISD is closely linked to CISM in nomenclature in many minds, the committee has adopted new language that is more generic and provides a more generalized approach to support members. The language does not preclude the practice of evidence supported interventions in any context, but will no longer suggest a specific model or format for delivery of such services.

The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees’ position has been supported through consensus by the National Center for PTSD, NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA, NAEMSP, and NAFTD.

1500-9  Log #19  (Chapter 11, 12, and Annex A)  Final Action: Reject

Submitter: Sara A. Jahnke, Center for Fire, Rescue & EMS Health Research, NDRI
Comment on Proposal No:  1500-85, 1500-86, 1500-103, 1500-104
Recommendation:  (Supports proposed changes to chapters and annex noted above as adopted by Technical Committee in ROP ballot reported April 5, 2011)
Substantiation:  Note: Supporting material is available for review at NFPA Headquarters.
Committee Meeting Action:  Reject
Committee Statement:  Submitter does not provide any textual changes for the committee to consider.
Denis G. Onieal, Gettysburg, PA  
1500-85, 1500-86, 1500-103, 1500-104

I support the proposed changes to chapters and annex noted above as adopted by Technical Committee in ROP ballot reported April 5, 2011.

I've reviewed the proposed changes to Chapters 11 & 12 (and annexes) and wholeheartedly concur with these changes for the following three reasons:

1. As a Deputy Fire Chief, on March 20, 1993, I gave an order to an off duty firefighter, Carlos Negron, at a multiple alarm fire during a blizzard. In the completion of that order, Firefighter Negron was killed. This happened in front of his 16 year-old son, Carlos Jr; the boy saw his father die. Obviously, this was traumatic for the members at the scene, the Negron family, and the department. Soon after returning to quarters, we were visited by two well-meaning CISD "debriefers." One was a 21 year old, third-year psychology student from a local college. He was a volunteer firefighter with the nickname "Doc" (that is how he was introduced to me). The other was a well meaning, dedicated firefighter that I knew, but he had absolutely no academic credentials - perhaps a weekend course. A wonderful man, but not much in the talent department. While I realize that they meant well, I have to tell you that I was angry that these two showed up. They were less than useful. No one in the station spoke with them, but it turned out that just about everyone at that fire was calling me over the next several weeks - on duty and off duty - to help them deal with the stress. There was no professional that I could refer them to, and each told me that they were disappointed with the two "CISD" team members that showed up. I wished that there were some licensed, trained professionals that I could have relied upon; but there weren't any.

2. There is a considerable body of science in both the military and civilian fields that have documented that amateur CISD debriefers not only are ineffective, but in many cases do more harm than good. This is science, not someone's opinion. I think that it's about time that NFPA standards have a scientific background rather than a group opinion. In the medical field, it is called evidence-based practice. We have the evidence, we have the science. Opinions should no longer count, especially in this case.

3. During the response to the World Trade Center event on 9-11, I was placed in charge of a team to work behind the scene to assist the FDNY reestablish their systems of command, control and communication. As luck would have it, about 2 weeks into the event, I received a call from a childhood friend - we went to grammar school together. He was a Catholic priest, a Monsignor who happened to be the Chaplain for one of the State Police Departments. He was placed in charge of all the chaplains of all faiths at Ground Zero - they were working in the temporary morgue and around the site. He said that they were working 2-3 hour shifts in the beginning, but after about a week, they were falling apart after about a half-hour. These professionals were overcome with grief and could no longer perform. Now, I realize that these chaplains have a lot of faith, and they're used to these kinds of situations and trained to deal with them - but even they were overwhelmed by the circumstances. If professionals can be troubled, we certainly need better than well-intentioned amateurs. We are discussing people's lives and their mental health; this isn't about fire trucks or PPE. As a retired fire chief who has experienced the worst, most stressful situation faced by a fireground commander; who witnessed firsthand the events of the World Trade Center and learned of the consequences of stress from a high-ranking religious professional; as one who is well aware of the scientific research surrounding PTSD and the consequences of ill-prepared, well intentioned debriefers; and finally as a father of a 100% disabled Marine who suffers from PTSD as a result of his Iraqi War experience; I beg you to change and improve the standards for our firefighters as recommended in these changes. The military long ago realized the critical importance of the right treatment; we cannot continue to rely on well-intentioned ill-prepared amateurs. Firefighters deserve better. You will make a tremendous improvement in the treatment they receive and help them to continue to lead productive lives.

Committee Meeting Action: Reject
Committee Statement: Submitter does not provide any textual changes for the committee to consider.
I'm writing to support all proposed changes to chapters and annex noted above as adopted by Technical Committee in ROP ballot reported April 5, 2011.

Substantiation: I'm writing to support the amendments to Chapters 11 and 12 and related annexes of the NFPA 1500, Standard on Fire Department Health and Safety Programs.

My background is that I've been working for the National Center for PTSD for 13 years, primarily in the areas of early intervention, resilience, post-disaster interventions, and combat stress. I've also been a part of the development team for an international consensus effort to clarify Peer Support Guidelines for high risk professions. In 2009, I was commissioned by the National Fallen Firefighters' Foundation (NFFF) Everyone Goes Home™ Initiative 13, to produce the following two manuals:

- Psychological First Aid for First Responders, designed to improve firefighters and EMS personnel customer service and support to the public they serve.
- Stress First Aid for Firefighters, which is designed to build on basic PFA principles and is specifically geared toward peer support personnel working with the behavioral health programs in fire and EMS organizations.

This initiative has employed a consensus process much like that used in developing standards in both medicine and firefighting. As part of this process, we have carefully reviewed the literature on early intervention in many fields of traumatic stress. As you know, Critical Incident Stress Debriefing (CISD) and other debriefing methods have not been shown to be effective in controlled studies, and for some participants, have resulted in long-term adverse outcomes. Consequently, a number of consensus documents and authoritative guidelines now recommend against routine debriefing. Therefore, I am in support of this revision deleting reference to CISD/CISM as a required or desirable intervention, and shifting its emphasis toward the use of a stepped care approach which incorporates both peer support and more evidence-based professional services.

Committee Meeting Action: Reject
Committee Statement: Submitter does not provide any textual changes for the committee to consider.
Grant Devilly, Griffith University

1500-85, 1500-86, 1500-103, 1500-104

(Supports proposed changes to chapters and annex noted above as adopted by Technical Committee in ROP ballot reported April 5, 2011)

I am writing to clarify the current understanding of post trauma reactions and clinical interventions. I am writing as an expert in the area who has published extensively in Australia, USA and England. I either have or am currently acting as a Government, Police and State Emergency Service advisor. I am also part of the expert panel on the Australian Guidelines for the treatment of Adults with ASD and PTSD. I also act as an expert witness in forensic cases - particularly related to post trauma sequelae.

Let me talk plainly and briefly. Psychological Debriefing (as in Critical Incident Stress Debriefing/Management) is dead. The evidence is that it hampers recovery and all treatment guidelines argue against its use. I can cite work after work (some of it my own) which demonstrates the noxious effects of debriefing, but really that is an academic approach that most companies do not really focus on. However, let me put it this way: in every case in which I have acted as an expert witness and where debriefing has been used on a claimant, the matter was settled out of court once the evidence had been compiled. No matter how much those purveyors of debriefing claim that they have "tweaked the noxious elements and now provide a full system of management rather than debriefing" the evidential coin still comes-up tails and the company being sued pays out lots of money to prevent it going to court. This perhaps is a real world application of the scientific data.

I would be more than happy to comment on any specific issues you have and would welcome the opportunity to speak further on this matter. Please advise me if you require any additional information.

Note: Supporting material is available for review at NFPA Headquarters.

Committee Meeting Action: Reject

Committee Statement: Submitter does not provide any textual changes for the committee to consider.
1500-13 Log #18

(Chapter 11, Chapter 12; Annex A)

Final Action: Reject

Submitter: Jeffrey Lohr, Dept. of Psychology Univ. Of Arkansas

Comment on Proposal No: 1500-85, 1500-86, 1500-103, 1500-104

Recommendation: Revise text as follows:

I am writing in response to the request for comments on the proposed revisions to the document. I am writing as an academic and clinical psychologist with interests in the scientific foundations for the implementation of post trauma prevention and intervention.

Substantiation: I strongly support the revision that re-titles Chapter 11 as "Behavior Health Program" and mandates referral of clinically significant cases to practitioners qualified to provide evidence-based care.

I strongly support the revision that re-titles Chapter 12 as "Occupational Exposure to Atypically Stressful Events." I also support the elimination of reference to Critical Incident Stress Debriefing (CISD) and Critical Incident Stress Management (CISM). I believe that interventions should be strictly voluntary, and that such interventions should be conducted by licensed and certified specialists such as psychiatrists, doctoral level psychologists, and social workers holding the MSW degree. It is they who will be most capable to provide evidence-based treatment that is consistent with current best practices and standards.

In the annexes to these chapters, I also support the removal of reference to CISD/M as the current scientific evidence indicates these interventions are generally ineffective and can be harmful in a meaningful number of cases.

This is not original material; its reference/source is as follows:


Committee Meeting Action: Reject

Committee Statement: Submitter does not provide any textual changes for the committee to consider. The committee reviewed existing evidence and revisited such review in light of comments on this subject.

The Committee maintains its original position that the changes adopted by the Committee represent and adequately reflect the current state of scientific and medical evidence and serve the best interest to the fire service and its members.

Current medical and scientific evidence demonstrates that “debriefing” is not effective in treating behavioral health issues and may be harmful. Given that CISD is closely linked to CISM in nomenclature in many minds, the committee has adopted new language that is more generic and provides a more generalized approach to support members. The language does not preclude the practice of evidence supported interventions in any context, but will no longer suggest a specific model or format for delivery of such services.

The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees’ position has been supported through consensus by the National Center for PTSD, NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA, NAEMSP, and NAFTD.
Log #8

Cynthia Dowdall, Northwest Fire District

Suggested additions to the NFPA 1500 Committee’s recent changes for Chapter 12 as follows:

Peer Support Teams who provide support to their peers, after a critical incident is now the national standard and should be reflected in the NFPA 1500. These teams are overseen by a certified or licensed Clinical Director that provides referrals to other mental health professionals, which is considered the next level of care (Continuum of Care see below).

12.1 General

12.1.1 The fire department’s physician certified or licensed Clinical Director shall maintain medical oversight of all clinical aspects of the peer support team and the members they work with.

12.1.2 The fire department shall adopt and utilize a written policy outlining its protocols to address occupational exposure to atypically stressful events (e.g., mass casualty incidents, firefighter line of duty fatality, or any other circumstance that falls outside the ordinary experience of its members). The Continuum of Care and the utilization of mental health and peer support team members, after critical incidents that may produce acute, delayed, or cumulative stressors involving line of duty death (police and fire), pediatric death, prolonged rescue efforts, high media profile incidents, and mass casualty incidents.

12.1.3 Protocols should clearly outline assistance and interventions and resources available to affected members along with the credentials of mental health and peer support team members that are providing services.

12.1.3.1 Participation in clinically related interventions shall be voluntary and at the member’s election. Resources for continued care will be made available.

12.1.3.2 Assessment of potential for sustained clinical impact should be available through the fire department’s behavioral health program. Resources for continued care will be made available by the department’s Clinical Director of Behavioral Health Services.

12.1.3.3 Where specialty treatment is indicated, referral should be made to licensed and certified specialists (e.g., psychiatrist, psychologist, clinical social worker) competent to provide evidence based treatment consistent with current best practices and standards of care as established guidelines. Referrals for continued care shall be made to certified or licensed behavioral health specialists (preferably who have experience working with firefighters).

12.1.4 Confidentiality will be upheld by all mental health and peer support team members with a further understanding of privileged communication being granted to peer support team members in the states where this has passed into law.

Substantiation: 1. Physicians are not licensed to provide health services unless they have a degree and are licensed to do so, just as those in behavioral health are not allowed to practice medicine without a license. Therefore, a certified or licensed Clinical Director of Behavioral Health Services should oversee Peer Support (hired by the department or EAP appointed certified or licensed mental health provider). Additionally, the medical aspect to psychiatric stressors is at the end of the spectrum on the continuum of care. It does not become clinical until a referral is made to the next level of care. To mix psychotherapy (clinical) into interventions (psychological first aid) on the front end is considered unethical (American Red Cross, ICISF).

12.1.1 The fire department’s physician certified or licensed Clinical Director shall maintain medical oversight of all clinical aspects of the peer support team and the members they work with.

2. Protocols are needed… Standard Operating Procedures (Standard Operating Guidelines) is the nomenclature utilized in the fire service and this same language use will help to provide guidance to Peer Support Teams overseen by a Clinical Director.

12.1.2 The fire department shall adopt and utilize a written policy outlining its protocols to address occupational exposure to atypically stressful events (e.g., mass casualty incidents, firefighter line of duty fatality, or any other circumstance that falls outside the ordinary experience of its members). The utilization of mental health and peer support team members, and their roles, after critical incidents that may produce acute, delayed, or cumulative stressors involving line of duty death (police and fire), pediatric death, prolonged rescue efforts, high media profile incidents, and mass casualty incidents.

3. These protocols need to outline the various interventions used for what situation and in what time frame. Some
members may not be affected, but choose to participate in an intervention to be of support to others. Protocols should clearly state the credentialing of mental health and peer support team members and their continued training, since this field is continually evolving. It should also describe criteria for implementing and maintaining a program.

12.1.3 Protocols should clearly outline assistance and interventions and resources available to affected members along with the credentials of mental health and peer support team members that are providing services.

4. All participation should be voluntary with other intervention strategies made available that includes peer support. Once again, clinical is considered therapy and should not be linked with interventions.

12.1.3.1 Participation in clinically related interventions shall be voluntary and at the member’s election. Resources for continued care will be made available.

5. An understanding of the continuum of care is necessary by mental health and peer support team members where members may need to be referred to a specialist (recovery and mitigation). The Clinical Director needs to oversee resources and referrals for privacy and best care practices. The words assessment and clinical impact need to be deleted because these words indicate diagnoses that can be career ending for a firefighter.

12.1.3.2 Assessment of potential for sustained clinical impact should be available through the fire department’s behavioral health program. Resources for continued care will be made available by the department’s Clinical Director of Behavior Health Services.

6. Referrals to certified of licensed mental health professionals who have an understanding of the fire service is important. Mental Health providers who do not have a clear understanding of the cultural aspects of the fire service can cause further harm.

12.1.3.3. Where specialty treatment is indicated, referral should be made to licensed and certified specialists (e.g.: psychiatrist, psychologist, clinical social worker) competent to provide evidence based treatment consistent with current best practices and standards of care as established guidelines. Referrals for continued care shall be made to certified or licensed behavioral health specialists (preferably who have experience working with firefighters).

7. Peer Support Teams for uniformed personnel are now being granted privileged communication in many states, such as Arizona. There, 12.1.4 was added.

12.1.4 Confidentiality will be upheld by all mental health and peer support team members with a further understanding of privileged communication being granted to peer support team members in the states where this has passed into law. Note: Supporting material is available for review at NFPA Headquarters.

This is not original material; its reference/source is as follows:
References to other research/including my own.

Committee Meeting Action: Reject
Committee Statement: This type of program should be under the auspices of the FD physician and not a clinical director.
Report on Comments – June 2012

1500-15 Log #22
(Chapter 12)

Final Action: Reject

Submitter: Melanie Smith-Thuret, Andover, MA
Comment on Proposal No: 1500-86
Recommendation: Revise text to read as follows:

The text and changes in the ROP need to revert back to the existing text that is found in the current NFPA 1500 edition for chapter 12

Chapter 12 Critical Incident Stress Program

12.1 General

12.1.1 The fire department physician shall provide medical guidance in the management of all clinical aspects of the critical incident stress program.

12.1.2 The fire department shall adopt and utilize a written policy that establishes a program designed to relieve the stress generated by an incident that could adversely affect the psychological and physical well-being of fire department members outlining its protocol to address occupational exposure to atypically stressful events (e.g., mass casualty, firefighter line of duty fatality, or any other circumstance that falls outside the ordinary exposure of its members).

12.1.3 The policy shall establish criteria for the implementation of the program. Protocols should clearly outline accountability and intervention available to affected members:

12.1.3.1 Participation in clinically related intervention shall be voluntary and at the member’s election.

12.1.3.2 Assessment of potential for sustained clinical impact should be available through the fire department’s behavioral health program.

12.1.3.3 Where specialty treatment is indicated or requested, members shall be referred to mental health professionals (e.g., psychiatrist, psychologist, clinical social worker) competent to provide evidence-based treatment consistent with current best practices and standards of care established by authoritative guidelines.

12.1.4 The program shall be made available to members for incidents including but not limited to mass casualties, large loss of life incidents, fatalities involving children, fatalities or injuries involving fire department members, and any other situations that affect the psychological and physical well-being of members.

Substantiation: Dear Sir/Madam,

I am writing this letter in defense of the benefits of utilizing the Critical Incident Stress Management (CISM) model with first responders that have experienced a critical incident. I am an Independently Licensed Clinical Social Worker (LICSW) in Massachusetts and have served as a clinician on the Boston Fire/Metro Fire CISM team for 3 years. Having worked with survivors of traumatic incidents for 17 years, I have found the CISM model to be incredibly beneficial when conducted appropriately. Although, CISM is not therapy, I have seen dramatic, positive, psychological outcomes in those individual that were able to participate in this type of intervention following a critical incident. I feel that it is crucial that these teams and this type of intervention continue to be made available to first responders in Massachusetts.

Lastly, I reject any of the proposed changes to the current 2007 edition NFPA Standards 1500, Chapter 12.

Respectfully,

Melanie Smith-Thuret, M.S., MSW, LICSW

Committee Meeting Action: Reject

Committee Statement: Submitter does not provide any textual changes for the committee to consider. The committee reviewed existing evidence and revisited such review in light of comments on this subject.

The Committee maintains its original position that the changes adopted by the Committee represent and adequately reflect the current state of scientific and medical evidence and serve the best interest to the fire service and its members.

Current medical and scientific evidence demonstrates that “debriefing” is not effective in treating behavioral health issues and may be harmful. Given that CISD is closely linked to CISM in nomenclature in many minds, the committee has adopted new language that is more generic and provides a more generalized approach to support members. The language does not preclude the practice of evidence supported interventions in any context, but will no longer suggest a specific model or format for delivery of such services.

The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees’ position has been supported through consensus by the National Center for PTSD, NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA, NAEMSP, and NAFTD.
Chapter 12 Critical Incident Stress Program

Occupational Exposure to Atypically Stressful Events

12.1 General

12.1.1 The fire department physician shall provide medical guidance in the management of a critical aspect of the critical incident stress program.

12.1.2 The fire department shall adopt and utilize a written policy that establishes a program designed to relieve the stress generated by an incident that could adversely affect the psychological and physical well-being of fire department members outlining its protocols to address occupational exposure to atypically stressful events (e.g., mass casualty incident, firefighter line of duty fatality, or any other circumstance that falls outside the ordinary experience of its members).

12.1.3 The policy shall establish criteria for the implementation of the program. Protocols should clearly outline assistance and intervention available to affected members:

- 12.1.3.1 Participation in clinically related interventions shall be voluntary and at the member's election.
- 12.1.3.2 Assessment of potential for sustained clinical impact should be available through the fire department's behavioral health program.
- 12.1.3.3 Where opociality treatment is indicated, referral should be made to licensed and certified professionals (e.g., psychiatrist, psychologist, clinical social worker) competent to provide evidence-based treatment consistent with current best practices and standards of care as established by authoritative guidelines.

12.1.4 The program shall be made available to members for incidents including but not limited to mass casualties, large life loss incidents, fatalities involving children, fatalities or injuries involving fire department members, and any other situations that affect the psychological and physical well-being of members.

Substantiation: The Commonwealth of Massachusetts and many other states, as well as federal agencies, have adopted the International Critical Incident Stress Foundation model as a "standard of care" for the following reasons:

- There is simply no other methodology that can compare to other than CISM as a comprehensive, well-developed, field-tested, and appropriate standard of care in this specialized work with firefighters and first responders.
- CISM provides a structured, systematic approach to the management of a "critical incident" in the fire service from even before notification of an incident (in its "pre-incident education component) to the incident aftermath, which is totally compatible with existing incident command training, and the operational focus of emergency services;
- It is based on "normal reactions of normal firefighters to abnormal events," taking a non-judgmental approach consistent with what has been learned from combat stress and disaster psychology research;
- The goal of all CISM interventions is to lessen the impact of the event, and accelerate normal coping mechanisms, as a subset of the overall field crisis intervention; it does not claim to "cure" anything;
- CISM is not therapy, does not meet the conditions necessary for psychotherapy, does not conflict with on-going psychotherapeutic work, and makes no therapeutic claims: it is an intervention for a critical incident, just as AA or other well-established self-help groups represent interventions for other conditions;
- It has almost 30 years of data, studies, articles, surveys, and research behind it, principle among those 55 research efforts which have attempted to capture the essence of why CISM seems to work so well in front-line emergency service units, and why it keeps being requested from the field;
- It is a peer-driven, clinically-guided partnership, which often makes extensive use of emergency services chaplaincy, to address spiritual aspects of the sense of loss and grief which accompany critical incidents;
- CISM is a largely volunteer movement which is not money-driven, and all interventions protect confidentiality;

Criticisms and Contrary Research:

CISM has always been subject to critique and opposition, mostly from the clinical and academic community, beginning with McFarland et al. when in its infancy as CISD. CISM has not only always acknowledged those critiques, it has bent over backward to give them their due, and share them with as much objectivity as possible. The Foundation has acted with integrity in widely publicizing the contrary studies, and restraint in the manner in which it has responded to them. The same cannot always be said of its major detractors, one of whom wrote, in response to the observation that first
responders seem to really like CISM: "I like jelly doughnuts, too, but that doesn't mean they're good for me." Another leadership figure at a trauma conference when confronted by a woman from Virginia who was puzzled by the attack on a method which had helped her local rescue squad so much after a flood responded "addicts like candy laced with morphine, too, but that doesn't mean it's good for them." A third author, well known in the emergency services field, wrote in a national emergency service magazine, "this work is much to serious to be left to peers," suggesting that those who cannot handle it probably should not be in the service in the first place, and those who legitimately need help should seek individual psychotherapy.

There is no question that CISM can be done poorly. So can any intervention. In the fire service, if the first arriving officer fails to conduct an adequate scene size-up, fails to prepare incoming units and communicate with transmissions and an assessment, fails to effectively attack the fire, fails to establish an adequate water supply, and does not transfer command in person, should we throw out Firefighter I/II training, Company Officer training, and Incident Command? If an ambulance crew facing an offset head-on collision with air-bag deployment and windshield starring walks a patient to the back of the ambulance and has the patient climb in, sizes the collar wrongly, and inadequately secures the patient to a backboard, do we throw out "C-spine precautions"?

Obviously not. These are training issues. CISM, just as with any other operational standard of care, requires training, practice, and accountability.

If we look at sources often cited as damaging to CISM such as the post-911 "Cochrane Report"-what do we find? The Cochrane report established at least four important criteria for any crisis intervention method purporting to help those in crisis, during and after a multi-casualty, multi-day, collapsed structure, multi-line of duty death event:

An early intervention component. Research identified the primacy of early intervention in disasters (as in combat stress research, immediacy as well as proximity, and a duty-expectant attitude-turn out to be crucial. CISM begins before a disaster strikes, in pre-incident training designed to reduce to element of surprise, provide "stress inoculation," and promote resiliency. In trauma work, psychological or medical, "time" does not heal all wounds, time and energy do. Simply allowing time to pass without an action component deepens the risk of infection to an open wound, and deepens the initial psychological shock and disbelief following a disaster);

Multi-Components in the method. (no one size fits all; no one method is so all encompassing that it works for all firefighters regardless of degree of exposure. Using the hazmat analogy of a "tiered response," CISM size-up includes which units need what interventions, keeping in mind the "bulls eye" theory taught in the assessment part of CISM: similar to the hot, warm, and cool zones in hazmat, not everyone is exposed to the "baddest and the maddest and the saddest," but those who are require significant resources, while those who are not may only need educational and informational approaches);

The Temporal Aspect: "Timing is everything" (CISM teaches that the same intervention performed on day one may not be appropriate six months out from the event. The intervention must be matched not only to the target group, but with what stage of the disaster its members of service are experiencing, and where they are with their own recovery);

The method must be able to be promulgated (no matter how good the method, if it cannot be taught, if there is no body of literature of evidence on which it is based, if there is no text, or if it cannot be "manualized" as a crisis intervention tool for large numbers of disaster workers, it will not be useful for training and preparation. CISM core courses all have instructional manuals, some on their fourth revisions, and are constantly being upgraded).

No other crisis intervention systematically addresses the needs of first responders in all of the above areas as well as CISM. The "early intervention aspect is well-addressed through many of its techniques, including demobilizations, crisis management briefings, III's, consultation to command, and chaplaincy compassionate presence. All have many years of growth and development behind them. The "multi-component" aspect speaks for itself. There are fourteen core components to the CISM methodology. The "temporal" aspect is a crucial part of CISM training: every component is taught with an appropriate time frame for its implementation (defusing within on the first 12 hours if possible, etc).

Finally, the "manualized" issue is addressed by the comprehensive instructional manuals required for each course, replete with course outlines, goals and objectives, references, and practicum exercises.

"Lack of research"

Since 1983 and the publishing of Jeff Mitchell's original article "When Disaster Strikes" in JEMS magazine, CISM has had a greater body of history, literature, articles, research, and reporting attached to it than any other method specifically designed to reduce the harmful effects of traumatic stress exposure in firefighters and first responders. CISM has been an open book, including 55 major studies available online through the Foundation.

As mentioned before, CISM has accumulated its detractors. One of the principal criticisms has been the dearth of "RCT's" (randomly-controlled trials) studies associated with CISM research, as well as matching for "control" and "experimental" groups on background variables such as socio-economic status, age, ethnicity, and gender, etc. Some of the normal "bells and whistles" expected in social science research- including a large "N" or sample size- have been difficult to provide in CISM studies, although not impossible.
The Foundation has acknowledged this, while pointing to those researchers who have been able to address some of these issues, notably Raymond Flannery Jr., former Director of Crisis Services for the Department of Mental Health in Massachusetts, including not only his own Assaulted Staff Action Program,” (ASAP), but also his “Meta-Analysis of CISM research;” Atle Dryegrov, Director of the Center for Crisis Psychology in Norway, and research studies conducted with employees exposed to bank robberies in the UK.

Research in CISM poses some unique challenges. It is not easy- at least from an ethical standpoint- to create a "control" group of firefighters who were not offered CISM in the event of a tragedy, or from whom it was withheld, to compare with those who were. But these issues can be dealt with creatively, which the Foundation actively supports. As well, other types of studies beyond those with "RCT’s" can be used in social science research, including the "case study" method from the field of social work, which can have equal value in a different way. CISM is not alone in the field of human services in facing this problem, and remains a "work in progress."

Kurt Lewin once wrote, "there's nothing so practical as a good theory." In a disaster where "structure is an antidote to chaos," it is essential to have a multi-component, flexible methodology.

Committee Meeting Action: Reject

Committee Statement: Submitter does not provide any textual changes for the committee to consider. The committee reviewed existing evidence and revisited such review in light of comments on this subject.

The Committee maintains its original position that the changes adopted by the Committee represent and adequately reflect the current state of scientific and medical evidence and serve the best interest to the fire service and its members.

Current medical and scientific evidence demonstrates that “debriefing” is not effective in treating behavioral health issues and may be harmful. Given that CISD is closely linked to CISM in nomenclature in many minds, the committee has adopted new language that is more generic and provides a more generalized approach to support members. The language does not preclude the practice of evidence supported interventions in any context, but will no longer suggest a specific model or format for delivery of such services.

The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees’ position has been supported through consensus by the National Center for PTSD, NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA, NAEMSP, and NAFTD.
12.1 General

12.1.1 The fire department physician shall provide medical guidance in the management oversight of all clinical aspects of the critical incident stress program.

12.1.2 The fire department shall adopt and utilize a written policy that establishes a program designed to relieve the stress generated by an incident that could adversely affect the psychological and physical well-being of fire department members. Outlining its protocols to address occupational exposure to atypically stressful events (e.g., mass casualty incidents, firefighter line of duty fatality, or any other circumstance that falls outside the ordinary experience of its members).

12.1.3 The policy shall establish criteria for the implementation of the program. Protocols should clearly outline: 
- Acceptance and intervention available to affected members;
- Participation in clinically related interventions shall be voluntary and at the member’s election;
- Assessment of potential for sustained clinical impact should be available through the fire department’s behavioral health program;
- Where specialty treatment is indicated, referral should be made to licensed and certified specialists (e.g., psychiatrist, psychologist, clinical social worker) competent to provide evidence-based treatment consistent with current best practices and standards of care as established by authoritative guidelines.

12.1.4 The program shall be made available to members for incidents including but not limited to mass casualties, large life loss incidents, fatalities involving children, fatalities or injuries involving fire department members, and any other situations that affect the psychological and physical well-being of members.

Substantiation: Introduction

My name is Hayden Duggan and I am a Deputy Fire Chief, Hubbardston, Mass. Fire Department, an EMT-Intermediate #828-442, and a licensed psychologist in the Commonwealth of Massachusetts.

I am writing this letter as a clinician and peer, in support of maintaining Critical Incident Stress Management as the standard of care for traumatic stress services to firefighters, and in defense of CISM as a representing “best practices” in serving those who serve. As the clinician to the Massachusetts State-wide Peer Assistance Network Board of Directors, I am urgently requesting that you delete either the term “critical incident,” or the reference to what should be updated as “Critical Incident Stress Management” or CISM (debriefings - CISD’s- are but one component in a multi-component system).

The Commonwealth of Massachusetts- and many other states, as well as federal agencies-adopted the International Critical Incident Stress Foundation model as a “standard of care” for the following reasons:

- There simply is no other methodology that can compare to other than CISM as a comprehensive, well-developed, field-tested, and appropriate standard of care in this specialized work with firefighters and first responders;
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- CISM is not therapy, does not meet the conditions necessary for psychotherapy, does not conflict with on-going psychotherapeutic work, and makes no therapeutic claims: it is an intervention for a critical incident, just as AA or other well-established self-help groups represent a interventions for other conditions;
- It has almost 30 years of data, studies, articles, surveys, and research behind it, principle among those 55 research efforts which have attempted to capture the essence of why CISM seems to work so well in front-line emergency service units, and why it keeps being requested from the field;
- It is a peer-driven, clinically-guided partnership, which often makes extensive use of emergency services chaplaincy, to address spiritual aspects of the sense of loss and grief which accompany critical incidents;
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CISM has always been subject to critique and opposition, mostly from the clinical and academic community, beginning with McFarland et al. when in its infancy as CISD. CISM has not only always acknowledged those critiques, it has bent over backward to give them their due, and share them with as much objectivity as possible. The Foundation has acted with integrity in widely publicizing the contrary studies, and restraint in the manner in which it has responded to them. The same cannot always be said of its major detractors, one of whom wrote, in response to the observation that first responders seem to really like CISM: "I like jelly doughnuts, too, but that doesn't mean they're good for me." Another leadership figure at a trauma conference-when confronted by a woman from Virginia who was puzzled by the attack on a method which had helped her local rescue squad so much after a flood- responded "addicts like candy laced with morphine, too, but that doesn't mean it's good for them." A third author, well known in the emergency services field, wrote in a national emergency service magazine, "this work is much to serious to be left to peers," suggesting that those who cannot handle it probably should not be in the service in the first place, and those who legitimately need help should seek individual psychotherapy.

There is no question that CISM can be done poorly. So can any intervention. In the fire service, if the first arriving officer fails to conduct an adequate scene size-up, fails to prepare incoming units and communicate with transmissions and an assessment, fails to effectively attack the fire, fails to establish an adequate water supply, and does not transfer command in person, should we throw out Firefighter II training, Company Officer training, and Incident Command? If an ambulance crew facing an offset head-on collision with air-bag deployment and windshield starring walks a patient to the back of the ambulance and has the patient climb in, sizes the collar wrongly, and inadequately secures the patient to a backboard, do we throw out "C-spine precautions"?

Obviously not. These are training issues. CISM, just as with any other operational standard of care, requires training, practice, and accountability.

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1. An early intervention component. Research identified the primacy of early intervention in disasters (as in combat stress research, immediacy- as well as proximity, and a duty-expectant attitude- turn out to be crucial. CISM begins before a disaster strikes, in pre-incident training designed to reduce to element of surprise, provide "stress inoculation," and promote resiliency. In trauma work, psychological or medical, "time" does not heal all wounds, time and energy do. Simply allowing time to pass without an action component deepens the risk of infection to an open wound, and deepens the initial psychological shock and disbelief following a disaster); Multi-Components in the method (no one size fits all; no one method is so all encompassing that it works for all firefighters regardless of degree of exposure. Using the hazmat analogy of a "tiered response," CISM size-up includes which units need what interventions, keeping in mind the "bulls eye" theory taught in the assessment part of CISM: similar to the hot, warm, and cool zones in hazmat, not everyone is exposed to the "baddest and the maddest and the saddest," but those who are require significant resources, while those who are not may only need educational and informational approaches);

2. The Temporal Aspect: "Timing is everything" (CISM teaches that the same intervention performed on day one may not be appropriate six months out from the event. The intervention must be matched not only to the target group, but with what stage of the disaster its members of service are experiencing, and where they are with their own recovery); The method must be able to be promulgated (no matter how good the method, if it cannot be taught, if there is no body of literature of evidence on which it is based, if there is no text, or if it cannot be "manualized" as a crisis intervention tool for large numbers of disaster workers, it will not be useful for training and preparation. CISM core courses all have instructional manuals, some on their fourth revisions, and are constantly being upgraded).

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"Lack of research"

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As mentioned before, CISM has accumulated its detractors. One of the principal criticisms has been the dearth of "RCT's" (randomly-controlled trials) studies associated with CISM research, as well as matching for "control" and "experimental" groups on background variables such as socio-economic status, age, ethnicity, and gender, etc. Some of the normal "bells and whistles" expected in social science research- including a large "N" or sample size- have been difficult to provide in CISM studies, although not impossible. The Foundation has acknowledged this, while pointing to those researchers who have been able to address some of these issues, notably Raymond Flannery Jr., former Director of Crisis Services for the Department of Mental Health in Massachusetts, including not only his own Assaulted Staff Action Program," (ASAP), but also his "Meta-Analysis of CISM research;" Atle Dryegrov, Director of the Center for Crisis Psychology in Norway, and research studies conducted with employees exposed to bank robberies in the UK.

Research in CISM poses some unique challenges. It is not easy- at least from an ethical standpoint- to create a "control" group of firefighters who were not offered CISM in the event of a tragedy, or from whom it was withheld, to compare with those who were. But these issues can be dealt with creatively, which the Foundation actively supports. As well, other types of studies beyond those with "RCT's" can be used in social science research, including the "case study" method from the field of social work, which can have equal value in a different way. CISM is not alone in the field of human services in facing this problem, and remains a "work in progress."

**On a personal note**

I have seen the need for CISM experience since I began in the fire service in 1976, and lost a 12 year old child in a structure fire our department responded to. I had a young daughter at home at that time. I am grateful to the CISM method which, years later, enabled me to finally make that traumatic event past, when hours of standard psychotherapy and significant amounts of self-medication did not.

At the Massachusetts Firefighting Academy, I work as the Co-Coordinator of Staff Services, and have state-wide exposure to critical incidents. I also serve as a clinical director for a critical incident stress management team (the greater Lowell, MA. Team). In the town in which I live, I have been both a call and part-time firefighter for 17 years, and currently serve as the Deputy Chief. I have also seen CISM at work in other jurisdictions, as the chief psychologist for the Boston Emergency Medical Services Peer Support Unit since 1989, and the clinical director of the Boston Police Critical Incident Support Team since 1997. My wife and I founded the On-Site Academy, a non-profit, largely volunteer residential treatment and training center for first responders created in 1991, where we do advanced trauma treatment for first responders suffering from Post-Traumatic Stress, and make extensive use of the CISM methodology as well as others.

As a clinician I have the responsibility to assess CISM critically, maintain clinical credibility beyond CISM, and be open to other ideas. I make it a point to attend trauma conferences of all types, and to be exposed to many other treatment modalities, from Eye Movement Desensitization and Reprocessing to Thought Field Therapy. I received my undergraduate and graduate degrees from Harvard University, and wrote two books, one on empathy, and one on crisis intervention (Lexington Books). I try to stay current with main trends in the field of post-traumatic stress beyond the fire service.

However, I have yet to find a serious alternative to the breadth and scope of the CISM methodology, and the tremendous wealth of data, field experience, and "roll-outs" of major interventions across the country, represented by the CISM method and the work of the Foundation.

I have seen the benefits of CISM first hand. I had the privilege of being one of many who responded to Oklahoma City after the bombing of the Murrah Building April 19, 1993. I also spent 8 days at the Worcester Fire from the time of notification to the recovery of the last firefighter. With the Boston Fire Critical Incident Team, and Boston Police, I served 25 days at the corner of West and Vessey in lower Manhattan working the CISM staging area in 911. In all those incidents, we did no debriefings until after the sites were closed down, because firefighters were not ready for them. All the other CISM interventions, particularly 1:1 peer support, were utilized, however.

Kurt Lewin once wrote, "there's nothing so practical as a good theory." In a disaster where "structure is an antidote to chaos," it is essential to have a multi-component, flexible methodology.

**Conclusions**

Gordon Alport (Yale University, 1955) wrote:

"the surest way to lose truth is to pretend one wholly possesses it."

CISM remains, and always has been, open to improvement, and alternative ideas. But for the NFPA to abandon it now would be a giant step backwards, and the antithesis of where we need to go to improve the movement to serve those who serve, and to prevent post-traumatic stress symptoms from developing among our firefighting personnel.

**Committee Meeting Action:** Rejected

**Committee Statement:** Submitter does not provide any textual changes for the committee to consider. The committee reviewed existing evidence and revisited such review in light of comments on this subject.
The Committee maintains its original position that the changes adopted by the Committee represent and adequately reflect the current state of scientific and medical evidence and serve the best interest to the fire service and its members.

Current medical and scientific evidence demonstrates that “debriefing” is not effective in treating behavioral health issues and may be harmful. Given that CISD is closely linked to CISM in nomenclature in many minds, the committee has adopted new language that is more generic and provides a more generalized approach to support members. The language does not preclude the practice of evidence supported interventions in any context, but will no longer suggest a specific model or format for delivery of such services.

The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees’ position has been supported through consensus by the National Center for PTSD, NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA, NAEMSP, and NAFTD.
12.1.1 The fire department shall provide clinical medical guidance in the management oversight all clinical aspects of the critical incident stress management (CISM) program.

12.1.2 The fire department shall adopt and utilize a written policy that establishes a program designed to relieve the stress generated by a critical incident that could adversely affect the psychological and physical well-being of fire department members outlining its protocol to address occupational exposure to atypically stressful events (e.g., mass casualty incidents, firefighter line of duty fatality, or any other circumstance that falls outside the ordinary experience of its members):

12.1.3 The policy will clearly outline a set of minimum standards which the CISM Team will adhere to: shall describe criteria for the implementation of the program. Protocols should clearly outline the assistance and multi-tiered interventions available to affected members.

12.1.3.1 Participation in clinically related interventions shall be voluntary and at the member’s election. The policy shall outline a comprehensive, systematic, multi-component, voluntary program of critical incident stress management which provides for supervision and consultation by CISM trained mental health professionals. Potential CISM team members should be carefully assessed prior to acceptance and there should be a mechanism for the removal of personnel from a team who fail to adhere to standards of practice.

12.1.3.2 Assessment of potential for sustained clinical emotional impact should be ongoing and available through the fire department’s behavioral health to all members of the department.

12.1.3.3 Where specialty treatment is indicated after an occurrence, timely referral should be made to licensed and certified mental health personnel (e.g., psychiatrist, psychologist, clinical social worker) competent to provide evidence-based treatment consistent with current best practices and standards of care as established by authoritative guidelines.

12.1.4 The CISM program shall be made available to members for incidents including but not limited to mass casualties, large life loss incidents, fatalities involving children, fatalities or injuries involving fire department members and any other situations that affect the psychological and emotional well-being of fire department members.

Substantiation: Critical Incident Stress Management is a comprehensive, systemic and integrated multi-tactic crisis intervention approach to help manage and mitigate stress after a critical incident. CISM is a coordinated program of tactics, designed to lessen the impact of a critical incident, and accelerate normal coping mechanisms. CISM is a peer driven, clinically guided partnership between mental health professionals and highly trained peer interventionists; it is not therapy, and makes no therapeutic claims.

A CISM team adhering to the standards of the International Critical Incident Stress Foundation will commit themselves to full participation in a comprehensive, systemic, integrated and multi component program of crisis intervention. They should never engage in stand alone interventions, and should be carefully supervised and advised by CISM trained mental health professionals. Potential CISM team members should be carefully assessed before acceptance, mechanisms must be in place for the removal of team personnel who fail to adhere to acceptable standards of practice in the CISM field.

Since the first article on CISD written by Jeffrey Mitchell in 1983 CISM has been extensively studied and undergone numerous changes. One important change was more clearly defining that Critical Incident Stress Debriefing, CISD, is only one component of the ICISF or Mitchell model of CISM. CISD is a specific seven step group crisis intervention tool designed to assist a homogenous group of people after an exposure to the same significant traumatic event, it should never be provided outside of an integrated package of interventions within the CISM program. To date there has never been a study that indicates that harm has been done by any CISD service if the personnel providing the intervention have been properly trained in CISM and they adhere to well published and internationally accepted standards of CISM practice. Every negative outcome study of CISM has been methodologically flawed leading Olsen et al to write in 2001 that users of the Cochrane reviews “should interpret the reviews cautiously” and “some Cochrane reviews have need of correction and improvement.” (p.830)

There is evidence that CISM conducted correctly benefits individuals at occupational risk of trauma. Over forty studies, including RCTs in support of CISM can be provided; and the research continues. In 2010 an article written by Hawker et al and published in the journal Clinical Psychology and Psychotherapy reference recent findings by Adler in 2009 and
Deahl et al in 2001 as a step in the right direction in providing RCT evidence that debriefing is beneficial for the groups we work with.

**Committee Meeting Action:** Reject

**Committee Statement:** Submitter does not provide any textual changes for the committee to consider. The committee reviewed existing evidence and revisited such review in light of comments on this subject.

The Committee maintains its original position that the changes adopted by the Committee represent and adequately reflect the current state of scientific and medical evidence and serve the best interest to the fire service and its members.

Current medical and scientific evidence demonstrates that "debriefing" is not effective in treating behavioral health issues and may be harmful. Given that CISD is closely linked to CISM in nomenclature in many minds, the committee has adopted new language that is more generic and provides a more generalized approach to support members. The language does not preclude the practice of evidence supported interventions in any context, but will no longer suggest a specific model or format for delivery of such services.

The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees’ position has been supported through consensus by the National Center for PTSD, NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA, NAEMSP, and NAFTD.
Chapter 12 Critical Incident Stress Program Occupational Exposure to Atypically Stressful Events

12.1 General

12.1.1 The fire department physician shall provide medical guidance in the management of all clinical aspects of the critical incident stress program.

12.1.2 The fire department shall adopt a written policy that establishes a program designed to relieve the stress generated by an incident that could adversely affect the psychological and physical well-being of fire department members, outlining its protocol to address occupational exposure to atypically stressful events (e.g., mass casualty incidents, firefighter line of duty fatality, or any other circumstance that falls outside the ordinary experience of its members).

12.1.3 The policy shall establish criteria for the implementation of the program. Protocols should clearly outline the criteria and intervention available to affected members:

- 12.1.3.1 Participation in clinically related interventions shall be voluntary and at the member’s election.
- 12.1.3.2 Assessment of potential for sustained clinical impact should be available through the fire department’s behavioral health program.
- 12.1.3.3 Where specialty treatment is indicated on assessment, referral should be made to licensed and certified specialists (e.g., psychiatrist, psychologist, clinical social worker) competent to provide evidence-based treatment consistent with current best practices and standards of care established by authoritative guidelines.

12.1.4 The program shall be made available to members for incidents including but not limited to mass casualties, large life loss incidents, fatalities involving children, fatalities or injuries involving fire department members, and any other situations that affect the psychological and physical well-being of members.

Substantiation: Critical Incident Stress Management is a comprehensive, systemic and integrated multi-tactic crisis intervention approach to help manage and mitigate stress after a critical incident. CISM is a coordinated program of tactics, designed to lessen the impact of a critical incident, and accelerate normal coping mechanisms. CISM is a peer driven, clinically guided partnership between mental health professionals and highly trained peer interventionists; it is not therapy, and makes no therapeutic claims.

A CISM team adhering to the standards of the International Critical Incident Stress Foundation will commit themselves to full participation in a comprehensive, systemic, integrated and multi component program of crisis intervention. They should never engage in stand alone interventions, and should be carefully supervised and advised by CISM trained mental health professionals. Potential CISM team members should be carefully assessed before acceptance, mechanisms must be in place for the removal of team personnel who fail to adhere to acceptable standards of practice in the CISM field.

Since the first article on CISD written by Jeffrey Mitchell in 1983 CISM has been extensively studied and undergone numerous changes. One important change was more clearly defining that Critical Incident Stress Debriefing CISD is only one component of the ICISF or Mitchell model of CISM. CISD is a specific seven step group crisis intervention tool designed to assist a homogenous group of people after an exposure to the same significant traumatic event, it should never be provided outside of an integrated package of interventions within the CISM program. To date there has never been a study that indicates that harm has been done by any CISM service if the personnel providing the intervention have been properly trained in CISM and they adhere to well published and internationally accepted standards of CISM practice. Every negative outcome study of CISM has been methodologically flawed leading Olsen et al to write in 2001 that users of the Cochrane reviews "should interpret the reviews cautiously" and "some Cochrane reviews have need of correction and improvement." (p.830)

There is evidence that CISM conducted correctly benefits individuals at occupational risk of trauma. Over forty studies, including RCTs in support of CISM can be provided; and the research continues. In 2010 an article written by Hawker et al and published in the journal Clinical Psychology and Psychotherapy reference recent findings by Adler in 2009 and Deahl et al in 2001 as a step in the right direction in providing RCT evidence that debriefing is beneficial for the groups we work with.

The Boston Fire-Metro Fire CISM team has been providing crisis intervention to Boston Firefighters for more than twenty years and to the first responders in Ma Fire District 13, essentially greater Boston, for more than ten years. The
Boston Fire Metro Fire CISM team has also provided CISM based crisis intervention throughout New England and nationally after incidents such as the Worcester Cold Storage Fire, Hurricane Katrina, the World Trade Center Bombings, and recently the Tornado in Western Massachusetts. We have a combined fire experience of over four hundred years, and a combined CISM experience of well over two hundred years. During that time our team has both witnessed and benefitted from the positive effects of CISM.

Committee Meeting Action: Reject
Committee Statement: The committee reviewed existing evidence and revisited such review in light of comments on this subject.

The Committee maintains its original position that the changes adopted by the Committee represent and adequately reflect the current state of scientific and medical evidence and serve the best interest to the fire service and its members.

Current medical and scientific evidence demonstrates that “debriefing” is not effective in treating behavioral health issues and may be harmful. Given that CISD is closely linked to CISM in nomenclature in many minds, the committee has adopted new language that is more generic and provides a more generalized approach to support members. The language does not preclude the practice of evidence supported interventions in any context, but will no longer suggest a specific model or format for delivery of such services.

The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees’ position has been supported through consensus by the National Center for PTSD, NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA, NAEMSP, and NAFTD.

Submitted: Joseph R. Lynch, Yarmouth Port, MA
Comment on Proposal No: 1500-86
Recommendation: In order to maintain the integrity of the Critical Incident Stress Debriefing, the model should continue to follow the CISM model and the use of peer debriefers.
Substantiation: It would be a great injustice to the CISD process to follow the recommendations of Mr. Richard Gist. This program is put forth to help community members deal with tragedies being supported by their peers.
Committee Meeting Action: Reject
Committee Statement:Submitter does not provide any textual changes for the committee to consider. The committee reviewed existing evidence and revisited such review in light of comments on this subject.

The Committee maintains its original position that the changes adopted by the Committee represent and adequately reflect the current state of scientific and medical evidence and serve the best interest to the fire service and its members.

Current medical and scientific evidence demonstrates that “debriefing” is not effective in treating behavioral health issues and may be harmful. Given that CISD is closely linked to CISM in nomenclature in many minds, the committee has adopted new language that is more generic and provides a more generalized approach to support members. The language does not preclude the practice of evidence supported interventions in any context, but will no longer suggest a specific model or format for delivery of such services.

The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees’ position has been supported through consensus by the National Center for PTSD, NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA, NAEMSP, and NAFTD.
Submitter: Heidi Wright, Yarmouth Port, MA

Comment on Proposal No: 1500-86

Recommendation: In order to maintain the integrity of the Critical Incident Stress Debriefing, the model should continue to follow the CISM model and the use of peer debriefers. As a Licensed Mental Health Counselor, I see how well this process works as it currently stands.

Substantiation: It would be a great to the CISD process to follow the recommendations of Richard Gist. This program is put forth to help community members deal with tragedies being supported by their peers.

Committee Meeting Action: Reject

Committee Statement: Submitter does not provide any textual changes for the committee to consider. The committee reviewed existing evidence and revisited such review in light of comments on this subject.

The Committee maintains its original position that the changes adopted by the Committee represent and adequately reflect the current state of scientific and medical evidence and serve the best interest to the fire service and its members.

Current medical and scientific evidence demonstrates that “debriefing” is not effective in treating behavioral health issues and may be harmful. Given that CISD is closely linked to CISM in nomenclature in many minds, the committee has adopted new language that is more generic and provides a more generalized approach to support members. The language does not preclude the practice of evidence supported interventions in any context, but will no longer suggest a specific model or format for delivery of such services.

The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees’ position has been supported through consensus by the National Center for PTSD, NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA, NAEMSP, and NAFTD.
A key disadvantage in buddy breathing is that it is extremely difficult for two people to leave the hazardous atmosphere quickly while engaged in buddy breathing; simultaneously consuming air at a faster rate. The risk that both individuals will inhale sufficient products of combustion during the attempted buddy breathing operation, he collapsed before he could exit the building. He was rescued by other fire fighters and removed to a hospital before he could relate the circumstances regarding the first fire fighter. The first fire fighter was found dead some time later.

If the fire fighter had been trained to remove the victim completely from the building or from immediate physical danger if possible, a number of things would have been accomplished without endangering the rescuer’s life and with less risk to the victim fire fighter. If the rescuer had not compromised his SCBA, he would not have been affected by the products of combustion; he would have retained a greater air supply, and he would have either removed the victim fire fighter by himself or exited the area for additional assistance and alerted medical help.

The risk of both victim and rescuer exhausting their air supplies is another scenario associated with buddy breathing. In this case, what starts out as a rescuer–victim relationship ends up a victim–victim relationship, as the shared air supply is exhausted before exiting is possible.

The one scenario that does not allow exiting is that in which two or more persons are trapped and share air supplies by buddy breathing. In this case, survival is based upon the time it takes those outside to realize that persons are trapped, initiate rescue operations, and accomplish rescue. Unfortunately buddy breathing might only provide a simultaneous ending of multiple lives.
SCBA emergency procedures should be an integral part of any respiratory protection SCBA program, with written policies for the removal of victims, both civilian and fire service, from hazardous atmospheres without compromising the rescuer’s respiratory protection SCBA for any reason.

Factors that can limit the need for buddy breathing include the following:

1. A strong, well-administered respiratory protection SCBA program
2. Emphasis on user testing and inspection of respiratory protection SCBA
3. Required before-use and after-use testing and maintenance
4. Functional preventive maintenance program
5. Fireground management based upon safe operations with knowledge of fire development, building construction, and coordinated fire-fighting operations
6. Air management training based upon the type of structure the user is entering, which requires the user to be aware of the distance to exit the structure when the low-air alarm activates or when necessary to leave the structure
7. Quality breathing air
8. Personal alert safety system (PASS) devices and portable radios for interior fire-fighting teams
9. Thorough training in survival techniques, controlled breathing, and stress management
10. Accountability for interior fire-fighting crews
11. Physical fitness of fire fighters
12. Use of positive-pressure SCBA that are NIOSH-approved and that meet the requirements of NFPA 1981

NFPA, ANSI, IAFF, and most SCBA manufacturers do not recommend buddy breathing because it compromises one or more SCBA and can result in the needless impairment or death of either the rescuer or the victim, or both.

Substantiation: The committee has chosen to delete this text as it has already been addressed in this document as well as in NFPA 1404, *Standard for Fire Service Respiratory Protection Training* and the hopes are to reduce or eliminate confusion for the end user.

Committee Meeting Action: Accept
I am very concerned with the proposed language edits that Dr. Gist has proposed for the NFPA 1500 pertaining to eliminating the language on Critical incident Stress Management (1500-103, Log #23, A.11.1 to A.12.1.3(B). I would ask the Committee not to recommend the suggested change and to consider the supporting statements in the substantiation.

Before choosing to change the CISM/CISD system that has proven of great benefit in the past, the following papers should be carefully read, as I believe they bring clarity to the very confusing debate:


In sum, these papers argue at least two important points:

1. First, that Critical Incident Stress Debriefing (CISD) is the same as Critical Incident Stress Management (CISM). CISM is a multi-phase, multi-component continuum of care. Similar multi-phase, multi-component psychological intervention systems have been recommended since the early 1990s. Similar systems have been used in medicine for decades. Thus CISM seems consistent with best practices and there is no evidence of harm from the use of such a system.

2. However CISM is often confused with CISD (a small group crisis intervention discussion). Individual debriefings with medical patients have indeed been questioned, however, solid research on group CISD in the military has proven helpful, with the authors specifically responding to the debate around debriefing and commenting there was no evidence of harmful effects (*Adler. Journal of Consulting and Clinical Psychology, 2009*).

While it is clear that ANY intervention has the potential to cause harm, the same can be said of neglect.

**Committee Meeting Action:** Reject

**Committee Statement:** Submitter does not provide any textual changes for the committee to consider. The committee reviewed existing evidence and revisited such review in light of comments on this subject.

The Committee maintains its original position that the changes adopted by the Committee represent and adequately reflect the current state of scientific and medical evidence and serve the best interest to the fire service and its members.

Current medical and scientific evidence demonstrates that “debriefing” is not effective in treating behavioral health issues and may be harmful. Given that CISD is closely linked to CISM in nomenclature in many minds, the committee has adopted new language that is more generic and provides a more generalized approach to support members. The language does not preclude the practice of evidence supported interventions in any context, but will no longer suggest a specific model or format for delivery of such services.

The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees' position has been supported through consensus by the National Center for PTSD, NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA, NAEMSP, and NAFTD.
Debriefings are strictly confidential and are not a critique of the Incident. Information should be given on stress reactions and steps that members can take to relieve the symptoms so that they can continue 1 to 3 hours after the incident. Debriefings should encourage brief discussions of the event, which in themselves help to remember that an event is traumatic when experienced as such. Generally, debriefings should be held at a station within the department's behavioral health assistance program (Chapter 11).

Debriefings should encourage brief discussions of the event, which in themselves help to remember that an event is traumatic when experienced as such. Generally, debriefings should be held at a station within the department's behavioral health assistance program (Chapter 11).

Critical incident stress is the inevitable result of trauma experienced by fire service personnel. It cannot be prevented, but it can be relieved. Experiencing emotional aftershocks following a traumatic event is a very normal reaction and should not be perceived as evidence of weakness, mental instability, or other abnormality. Symptoms can appear immediately after the Incident, hours later or sometimes days or weeks later. The symptoms can last for a few days, weeks, or months. Occasionally a professional counselor could be needed. Knowing the signs and symptoms and how to respond to them after the occurrence of a critical Incident can greatly reduce the chance of more severe and long-term stress. Rapid Intervention, talking about the situation, and reassuring that these are normal reactions and feelings can help prevent more serious problems later on, such as family and marital problems. To provide the intervention, the fire department should have access to a critical incident debriefing (CID) team. The main objective of the CID team is to lessen the Impact of the critical incident, put it into the proper perspective, and help maintain a healthy outlook. The CID team should consist of other firefighters, support personnel, and mental health professionals specifically trained in stress-related counseling. The team should be well represented by all types of members whether volunteer, call, or career, and by all ranks. All members should have a minimum of a two day training seminar with continuing education in stress-related training as an ongoing part of the team's regular meetings. (Monthly meetings are recommended for active departments, while quarterly meetings could be sufficient for less active departments.) Any individual should be able to initiate the debriefing procedure simply by contacting his/her supervisor or officer or the dispatch center. A contact list of the CID team members should be available in the dispatch center. Debriefings should be held for incidents that have the potential for having a stressful impact on members. It is important to remember that an event is traumatic when experienced as such. Generally, debriefings should be held at a station within 1 to 3 hours after the incident. Debriefings should encourage brief discussions of the event, which in themselves help to alleviate a good deal of the stress. Debriefings are strictly confidential and are not a critique of the Incident. Information should be given on stress reactions and steps that members can take to relieve the symptoms so that they can continue normal activities as soon as the debriefing is over. Some common signs and symptoms of critical incident stress are fatigue, headaches, inability to concentrate, anxiety, depression, inappropriate emotional behavior, intense anger, irritability, withdrawal from the crew and/or family, change in appetite, increased alcohol consumption, and a change in sleeping patterns. To help alleviate some of the emotional pain, members can rest more, contact friends, maintain a normal schedule as possible, eat well balanced and scheduled meals, keep a reasonable level of activity to fight boredom, express feelings, and talk to loved ones. Recent studies and research also indicate that exercise, especially soon after an event, can greatly reduce mental pain. Member assistance programs should always be available to members. The CID team is often the first step in providing the help that is needed and should be ready to serve to help minimize stress-related injury. The fire departments written policy should indicate the responsibilities of the organization, its officers, and its members in ensuring that the impact of occupational events is systematically anticipated and considered. The policy should enhance support from officers, supervisors, and peers; and full integration where indicated with the department's behavioral health assistance program (Chapter 11).

Substantiation: Before choosing to change a system that has proven of great benefit in the past, the following papers should be carefully read, as I believe they bring clarity to the very confusing debate:


In sum, these papers argue at least two important points:
1. First, that Critical Incident Stress Debriefing (CISD) is not the same as Critical Incident Stress Management (CISM). CISM is a multi-phase, multi-component continuum of care. Similar multi-phase, multi-component psychological intervention systems have been recommended since the early 1990s. Similar systems have been used in medicine for decades. Thus CISM seems consistent with best practices and there is no evidence of harm from the use of such a system. Consistent with this view, recent research by Boscarino and colleagues has shown such crisis intervention to be superior to psychotherapy, while psychotherapy actually caused harm after the terrorist attacks of 9/11 (Boscarino J. Nervous and Mental Disease, 2011).

2. However CISM is often confused with CISD (a small group crisis intervention discussion). Individual debriefings with medical patients have indeed been questioned, however, solid research on group CISD in the military has proven helpful, with the authors specifically responding to the debate around debriefing and commenting there was 110 evidence of harmful effects (Adler. Journal of Consulting and Clinical Psychology, 2009). While it is clear that ANY intervention has the potential to cause harm, the same can be said of neglect.

In Connecticut last year, a firefighter took his life along the side of a rail line. While he had some work problems, family problems and substance abuse problems, they had started in his life over the past several years. On the cover, his suicide could easily have been dismissed by attributing his personal problems to sources in his personal life. However, the fact that he took his life 200 feet from a rail road crossing at the same exact spot where several years earlier he was the primary EMT working on a little girl who died as a result of a train vs. car crash, one cannot help but wonder if any of the tools available in Connecticut from the CT CISM Team could have helped this Firefighter. My information from members of that department is that no CISM system tools were used after that double fatal crash taking the life of a grandmother, granddaughter and seriously injuring the grandson.

The Fire Service does an excellent job of training Firefighters in the physical aspects of staying safe but needs to maintain a solid system of Critical Incident Stress Management to be ready when needed to support the psychological emergencies that arise.

This is not original material; its reference/source is as follows:
The wording in the comment comes from current language in the NFPA 1500-104 document and should remain as is.

Committee Meeting Action: Reject
Committee Statement: Submitter does not provide any textual changes for the committee to consider. The committee reviewed existing evidence and revisited such review in light of comments on this subject.

The Committee maintains its original position that the changes adopted by the Committee represent and adequately reflect the current state of scientific and medical evidence and serve the best interest to the fire service and its members.

Current medical and scientific evidence demonstrates that “debriefing” is not effective in treating behavioral health issues and may be harmful. Given that CISD is closely linked to CISM in nomenclature in many minds, the committee has adopted new language that is more generic and provides a more generalized approach to support members. The language does not preclude the practice of evidence supported interventions in any context, but will no longer suggest a specific model or format for delivery of such services.

The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees’ position has been supported through consensus by the National Center for PTSD. NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA, NAEMSP, and NAFTD.
Submitters: Carl Russell, Life Hope Consulting and Services

Comment on Proposal No: 1500-104

Recommendation: Substantial research has been conducted and reported since the last revision of this standard respecting occupational exposure to atypically stressful events and interventions directed toward mitigating their impact. Research has shown that Critical Incident Stress Management (CISM) is beneficial in mitigating the human stress response, especially in critical incident or traumatic stress. All fire departments and fire personnel should have access to CISM services. CISM is not to be confused with the Critical Incident Stress Debriefing (CISD), which is only one component of CISM. CISM is a multi-component, integrated, systematic, multi-phased set of protocols that are proven to mitigate symptoms of traumatic stress and help return to normal adaptive functioning.

Substantiation: Richard Gast, Kansas City (Missouri) Fire Department proposed to do away with Critical Incident Stress Management. There are a number of flaws in his proposal. CISM is not the same as a Critical Incident Stress Debriefing (CISD). It is true that the Debriefing model has been overused and abused, but it is still a valuable tool in many situations, especially if conducted by competent and experienced crisis interventionists. CISM is much broader than the CISD. For instance, teaching fire personnel about critical incident stress and the negative impact it has on people should be done by all departments. This pre-crisis training is just one component of CISM. Providing services to traumatized personnel is essential; however, there are a number of different kinds of interventions that are tailored for each situation. Instead of doing away with CISM, departments should be encouraged to seek as much training as possible. The International Critical Incident Stress Foundation has at least 20 courses that apply directly to the work of responders.

The following studies and papers have shown the importance of CISM:

Hawker, DM, Durkin, J, & Hawker, DSJ (2010). To debrief or not to debrief our heroes: That is the question. Clinical Psychology and Psychotherapy, Published online in Wiley Online Library (wileyonlinelibrary.com). DOI: 10.1002/cpp.730


For more information some of this research is on the web:

http://www.vocf.net/uploaded_project/effective-debriefing-inote.pdf

The negative research findings on CISM are based on faulty research. Researchers completely discounted the basic principles of CISM and failed to recognize that CISM is a mult-component, multi-phased, integrated system of protocols that are unique to every situation. What is imperative in any kind of CISM is that trained, competent, and experienced people should conduct it.

Committee Meeting Action: Reject

Committee Statement: Submitter does not provide any textual changes for the committee to consider. The committee reviewed existing evidence and revisited such review in light of comments on this subject.

The Committee maintains its original position that the changes adopted by the Committee represent and adequately reflect the current state of scientific and medical evidence and serve the best interest to the fire service and its members.

Current medical and scientific evidence demonstrates that “debriefing” is not effective in treating behavioral health issues and may be harmful. Given that CISD is closely linked to CISM in nomenclature in many minds, the committee has adopted new language that is more generic and provides a more generalized approach to support members. The language does not preclude the practice of evidence supported interventions in any context, but will no longer suggest a specific model or format for delivery of such services.

The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees’ position has been supported through consensus by the National Center for PTSD. NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA,
NAEMSP, and NAFTD.
Firefighters frequently experience trauma, death, and sorrow. Critical incident stress is a normal reaction experienced by normal people following an event that is abnormal. The emotional trauma can be serious. It can break through a person’s defenses suddenly, or slowly and collectively, so that the person can no longer function effectively. Critical incident stress is the inevitable result of trauma experienced by fire service personnel. It cannot be prevented, but it can be relieved. Experiencing emotional aftershocks following a traumatic event is a very normal reaction and should not be perceived as evidence of weakness, mental instability, or other abnormality. Symptoms can appear immediately after the incident, hours later or sometimes days or weeks later. The symptoms can last for a few days, weeks, or months. Occasionally a professional counselor could be needed. Knowing the signs and symptoms and how to respond to them after the occurrence of a critical incident can greatly reduce the chance of more severe and long-term stress.

Rapid intervention, talking about the situation, and reassuring that these are normal reactions and feelings can help prevent more serious problems later on, such as family and marital problems. To provide the intervention, the fire department should have access to a critical incident debriefing (CID) team. The main objective of the CID team is to lessen the impact of the critical incident, put it into the proper perspective, and help maintain a healthy outlook. The CID team should consist of other firefighters, support personnel, and mental health professionals specifically trained in stress-related counseling. The team should be well represented by all types of members whether volunteer, call, or career, and by all ranks. All members should have a minimum of a two day training seminar with continuing education in stress-related training as an ongoing part of the team’s regular meetings. (Monthly meetings are recommended for active departments, while quarterly meetings could be sufficient for less active departments.) Any individual should be able to initiate the debriefing procedure simply by contacting his/her supervisor or officer or the dispatch center. A contact list of the debriefing team members should be available in the dispatch center. Debriefings should be held for incidents that have the potential for having a stressful impact on members. It is important to remember that an event is traumatic when experienced as such.

Generally, debriefings should be held at a station within 1 to 3 hours after the incident. Debriefings should encourage brief discussions of the event, which in themselves help to alleviate a good deal of the stress. Debriefings are strictly confidential and are not a critique of the incident. Information should be given on stress reactions and steps that members can take to relieve the symptoms so that they can continue their normal activities as soon as the debriefing is over. Some common signs and symptoms of critical incident stress are fatigue, headaches, inability to concentrate; anxiety; depression; inappropriate emotional behavior; intense anger; irritability; withdrawal from the crew and/or family; change in appetite, increased alcohol consumption, and a change in sleeping patterns. To help alleviate some of the emotional pain, members can rest more, contact friends, maintain as normal a schedule as possible, eat well balanced and scheduled meals, keep a reasonable level of activity to fight boredom, express feelings, and talk to loved ones.

Recent studies and research also indicate that exercise, especially soon after an event, can greatly reduce mental pain. Member assistance programs should always be available to members. The CID team is often the first step in providing the help that is needed and should be ready to serve to help minimize stress-related injury. The fire department’s written policy should indicate the responsibilities of the organization, its officers, and its members in ensuring that the impact of occupational events is systematically anticipated and considered. The policy should enhance support from officers, supervisors, and peers; and full integration where indicated with the department’s behavioral health assistance program (Chapter 11).

Substantiation: The proposed changes do not seem to understand the vital difference between CISD and CISM, the following papers provide clarity:

- Hawker, DM, Durkin, J, & Hawker, DSJ (2010). To debrief or not to debrief our heroes: That is the question. Clinical Psychology and Psychotherapy, Published online in Wiley Online Library (wileyonlinelibrary.com). DOI: 10.1002/cpp.730
In sum, these papers argue at least two important points:

1. First, that Critical Incident Stress Debriefing (CISD) is not the same as Critical Incident Stress Management (CISM). CISM is a multi-phase, multi-component continuum of care. Similar multi-phase, multi-component psychological intervention systems have been recommended since the early 1990s. Thus CISM seems consistent with best practices and there is no evidence of harm from the use of such a system. Consistent with this view, recent research by Boscarino and colleagues has shown such crisis intervention to be superior to psychotherapy, while psychotherapy actually caused harm after the terrorist attacks of 9/11 (Boscarino J. Nervous and Mental Disease, 2011).

2. CISM is often confused with CISD (a small group crisis intervention discussion). Individual debriefings with medical patients have indeed been questioned, however, solid research on group CISD in the military has proven helpful, with the authors specifically responding to the debate around debriefing and commenting there was no evidence of harmful effects (Adler. Journal of Consulting and Clinical Psychology, 2009).

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Committee Meeting Action: Reject

Committee Statement: The committee reviewed existing evidence and revisited such review in light of comments on this subject.

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I recommend the deletion of this paragraph due to the contradictory nature of the claim. Before choosing to change a system that has proven of great benefit in the past, the following papers should be carefully read, as I believe they bring clarity to the very confusing debate:

- Hawker, DM, Durkin, J, & Hawker, DSJ (2010). To debrief or not to debrief our heroes: That is the question. Clinical Psychology and Psychotherapy, Published online in Wiley Online Library (wileyonlinelibrary.com). DOI: 10.1002/cpp.730

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2. However CISM is often confused with CISD (a small group crisis intervention discussion). Individual debriefings with medical patients have indeed been questioned, however, solid research on group CISD in the military has proven helpful, with the authors specifically responding to the debate around debriefing and commenting there was no evidence of harmful effects (Adler. Journal of Consulting and Clinical Psychology, 2009).

While it is clear that ANY intervention has the potential to cause harm, the same can be said of neglect. I have served Fire, Law Enforcement, EMS, Hospital and Federal Responders for the last 10 years in as a CISM/CISD trained responder. I have benefitted from these events as a volunteer fire fighter for

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Committee Meeting Action: Reject

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The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees’ position has been supported through consensus by the National Center for PTSD. NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA, NAEMSP, and NAFTD.
Firefighters frequently experience trauma, death, and sorrow. Critical incident stress is a normal reaction experienced by normal people following an event that is abnormal. The emotional trauma can be serious. It can break through a person's defenses suddenly, or slowly and collectively, so that the person can no longer function effectively. Critical incident stress is the inevitable result of trauma experienced by fire service personnel. It cannot be prevented, but it can be relieved. Experiencing emotional aftershocks following a traumatic event is a very normal reaction and should not be perceived as evidence of weakness, mental instability, or other abnormality. Symptoms can appear immediately after the incident, hours later or sometimes days or weeks later. The symptoms can last for a few days, weeks, or months. Occasionally a professional counselor could be needed. Knowing the signs and symptoms and how to respond to them after the occurrence of a critical incident can greatly reduce the chance of more severe and long-term stress.

Rapid intervention, talking about the situation, and reassuring that these are normal reactions and feelings can help prevent more serious problems later on, such as family and marital problems. To provide the intervention, the fire department should have access to a critical incident debriefing (CID) team. The main objective of the CID team is to lessen the impact of the critical incident, put it into the proper perspective, and help maintain a healthy outlook. The CID team should consist of other firefighters, support personnel, and mental health professionals specifically trained in stress-related counseling. The team should be well represented by all types of members whether volunteer, call, or career; and by all ranks. All members should have a minimum of a two day training seminar with continuing education in stress-related training as an ongoing part of the team's regular meetings. (Monthly meetings are recommended for active departments, while quarterly meetings could be sufficient for less active departments.) Any individual should be able to initiate the debriefing procedure simply by contacting his/her supervisor or officer or the dispatch center. A contact list of the debriefing team members should be available in the dispatch center. Debriefings should be held for incidents that have the potential for having a stressful impact on members. It is important to remember that an event is traumatic when experienced as such.

Generally, debriefings should be held at a station within 1 to 3 hours after the incident. Debriefings should encourage brief discussions of the event, which in themselves help to alleviate a good deal of the stress. Debriefings are strictly confidential and are not a critique of the incident. Information should be given on stress reactions and steps that members can take to relieve the symptoms so that they can continue their normal activities as soon as the debriefing is over. Some common signs and symptoms of critical incident stress are fatigue, headaches, inability to concentrate, anxiety, depression; inappropriate emotional behavior; intense anger, irritability; withdrawal from the crew and/or family; change in appetite, increased alcohol consumption, and a change in sleeping patterns. To help alleviate some of the emotional pain, members can rest more, contact friends, maintain as normal a schedule as possible, eat well balanced and scheduled meals, keep a reasonable level of activity to fight boredom, express feelings, and talk to loved ones.

Recent studies and research also indicate that exercise, especially soon after an event, can greatly reduce mental pain. Member assistance programs should always be available to members. The CID team is often the first step in providing the help that is needed and should be ready to serve to help minimize stress-related injury. The fire department's written policy should indicate the responsibilities of the organization, its officers, and its members in ensuring that the impact of occupational events is systematically anticipated and considered. The policy should enhance support from officers, supervisors, and peers; and full integration where indicated with the department's behavioral health assistance program (Chapter 11).

Substantiation: Before choosing to change a system that has proven of great benefit in the past, the following papers should be carefully read, as I believe they bring clarity to the very confusing debate:

- Hawker, DM, Durkin, J, & Hawker, DSJ (2010). To debrief or not to debrief our heroes: That is the question. Clinical Psychology and Psychotherapy, Published online in Wiley Online Library (wileyonlinelibrary.com). DOI: 10.1002/cpp.730
In sum, these papers argue at least two important points:

1. First, that Critical Incident Stress Debriefing (CISD) is not the same as Critical Incident Stress Management (CISM). CISM is a multi-phase, multi-component continuum of care. Similar multi-phase, multi-component psychological intervention systems have been recommended since the early 1990s. Thus CISM seems consistent with best practices and there is no evidence of harm from the use of such a system.

   Consistent with this view, recent research by Boscarino and colleagues has shown such crisis intervention to be superior to psychotherapy, while psychotherapy actually caused harm after the terrorist attacks of 9/11 (Boscarino J. Nervous and Mental Disease, 2011).

2. However CISM is often confused with CISD (a small group crisis intervention discussion). Individual debriefings with medical patients have indeed been questioned, however, solid research on group CISD in the military has proven helpful, with the authors specifically responding to the debate around debriefing and commenting there was no evidence of harmful effects (Adler. Journal of Consulting and Clinical Psychology, 2009).

   While it is unclear that ANY intervention has the potential to cause harm, the same can be said of neglect.

   In Connecticut last year, a firefighter took his life along the side of a rail line. While he had some work problems, family problems and substance abuse problems, they had started in his life over the past several years. On the cover, his suicide could easily have been dismissed by attributing his personal problems on sources in his personal life. However, the fact that he took his life 200 feet from a rail road crossing at the same exact spot where several years earlier he was the primary EMT working on a little girl who died as a result of a train vs. car crash, one cannot help but wonder if any of the tools available in Connecticut from the CT CISM Team could have helped this Firefighter. My information from members of that department is that no CISM system tools were used after that double fatal crash taking the life of a grandmother, granddaughter and seriously injuring the grandson.

   The Fire Service does an excellent job of training Firefighters in the physical aspects of staying safe but needs to maintain a solid system of Critical Incident Stress Management to be ready when needed to support the psychological emergencies that arise.

This is not original material; its reference/source is as follows:
The wording in the comment comes from current language in the NFPA 1500-104 document and should remain as is.

Committee Meeting Action: Reject

Committee Statement: The committee reviewed existing evidence and revisited such review in light of comments on this subject.

The Committee maintains its original position that the changes adopted by the Committee represent and adequately reflect the current state of scientific and medical evidence and serve the best interest to the fire service and its members.

Current medical and scientific evidence demonstrates that “debriefing” is not effective in treating behavioral health issues and may be harmful. Given that CISD is closely linked to CISM in nomenclature in many minds, the committee has adopted new language that is more generic and provides a more generalized approach to support members. The language does not preclude the practice of evidence supported interventions in any context, but will no longer suggest a specific model or format for delivery of such services.

The fire service and major fire service organizations have addressed these comments over the past five years as part of an overall Behavioral Health Program. Additionally, the committees’ position has been supported through consensus by the National Center for PTSD. NIOSH/CDC, National Crime Victim Center, Center for Study of Traumatic Stress, Employee Assistance Professional Association, Fire Health Research Group/KCUMB, IAFF, IAFC, NVFC, NFPA, NAEMSP, and NAFTD.
CISM is often confused with CISD (a small group crisis intervention discussion). The research using ‘individual debriefings’ with medical patients has been questioned and acknowledged to be flawed. It is also questioned the training of those who conducted the interventions used for this research. What is most important is (any kind of CISM should be conducted only by trained, competent and experienced people.) This should be included in the NFPA revision.

Richard Gist, of the Kansas City Missouri Fire Department, continues to use this flawed research. This only serves to muddy the waters when those who are not aware listen only to those who seek to confuse the issue. CISM does not use ‘individual debriefings’ with individuals. Debriefings are group interventions.

Solid research on group CISD in the military has proven helpful, with the authors specifically responding to the debate around debriefing and commenting there was no evidence of harmful effects.

CISM includes pre-incident education of our firefighters and family members, using individual conversations and group demobilizations, defusing and/or debriefings. It also includes follow-up referral to competent therapists skilled in working with the culture of firefighting. CISM includes family support and clergy support

Since Richard Gist has confused CISM with CISD I must question his motives for continuing to do this. While it is clear that any intervention has the potential to cause harm, as psychotherapy may do, the same can be said of neglect. CISM benefits our firefighters; let’s not take away a useful tool.

Additionally, the Everyone Goes Home, while an excellent program, does not address how to provide assistance to fire fighters. Many fire fighters will not seek counselor help. Peer support is the bridge to providing care.

Substantiation: Before choosing to change a system that has proven of great benefit to firefighters, the following papers should be read carefully. In particular the recent research by Boscarino and colleagues has shown such crisis intervention to be superior to psychotherapy, while psychotherapy actually caused harm after the terrorist attacks of 9/11.

This is not original material; its reference/source is as follows:

Committee Meeting Action: Reject

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