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**13. Psychological Support**

Frequently Asked Questions

**1. I’ve heard there is a new model for firefighter behavioral health. What’s the story?**

The new model for firefighter behavioral health was developed by the National Fallen Firefighters Foundation to fulfill Firefighter Life Safety Initiative 13 “firefighters and their family members must have access to counseling and psychological support.” The components of FLSI 13 represent a comprehensive plan that is the result of a three-year consensus process of translating state-of-the art research and best practices currently being utilized in civilian applications, the military and other high-risk professions and adapting them into behavioral assistance programs for members of the fire service and their families.

**2. Why do we need a new model?**

After decades of assisting the surviving family members and co-workers of fallen firefighters, the National Fallen Firefighters Foundation recognized that our firefighters deserve the best behavioral health assistance available. In the past, our industry usually took a reactive approach to behavioral health, and only offered “one-size-fits all” options after a firefighter had been negatively impacted by a traumatic event. While at one time that was the best that we could offer, current research has demonstrated that different people have varying levels of emotional resiliency. After exposure to a potentially traumatic event (a PTE), some folks bounce back quickly. Others need more time and possibly some assistance, and there are some individuals who will require clinical intervention to recover. Detailed research conducted over the last decade suggests that our traditional ways of providing assistance were not as helpful as we hoped and could even raise complications for some people; newer approaches based on better study and research are now available, and could potentially provide more effective approaches to providing care.

**3. What’s different about these new approaches?**

What makes FLSI 13 so different is that it helps firefighters and their family members to deal better with the problems of everyday living, and to build the psychological skills that they need to cope with personal, family and occupational stressors. By developing this emotional resiliency, individuals are then better equipped to deal with atypically stressful events, such as a multi-fatality event or a firefighter line-of-duty fatality. We recognize that in these situations, even the strongest individuals may need assistance to recover. When they do, screening mechanisms will get these firefighters the level of care that they need, and the clinicians available to help them will have quick, user-friendly, no-cost access to the training they need to provide your personnel with the best therapeutic interventions available.

**4. What improvements does the new model offer?**

This model represents a dramatic improvement in the way that fire and emergency departments handle occupational stress. FLSI 13 is a holistic approach, with a strong focus on building resiliency in dealing with everyday situations, both at work and at home. One aspect of the program helps firefighters and others to acquire useful skills to support one another; when the problem requires professional intervention, co-worker peers can help affected individuals to locate and utilize appropriate professional care. The same is true after a potentially traumatic event—if the firefighter needs help, the appropriate level of care will be available when they need it.

**5. Does the new model have to be adopted all-at-once, or can it be phased it?**

FLSI 13 is a comprehensive approach and its effectiveness will be greatly enhanced by adoption of the entire program rather than picking and choosing select pieces of the plan. As with any major change in fire service operations, there will be a transition period as organizations move to the new model. It might be useful to remember the history of our transition to widespread adoption of ICS. At first there was significant resistance, with holdouts who claimed that it was “overkill” to use it on every call. We have since come to realize that when we use ICS every day on every call, it becomes automatic. Like ICS, many of the skills that FLSI 13 fosters should be practiced by firefighters and EMS personnel every day, on every call. When these capabilities are ingrained in individuals and become part of the department culture, they will be there when needed. More importantly, their use will be automatic, even under the intense stress that major traumatic events inevitably bring.

**6. What are the components of the new model?**

***After Action Review*** is a post-incident assessment protocol adopted from the military “Hot Wash” model. It provides a meaningful mechanism for review and answering questions; relieves anxiety and uncertainty; and provides a safe segue into discussing the emotional impacts of the event if necessary. It should be used at the company or crew level on every call, *“every time wheels roll.”* Such daily use, like daily use of IMS, greatly enhances overall performance, builds a safer enterprise and provides a solid foundation for skills that become absolutely critical in major events.

***Curbside Manner: Stress First Aid for the Streets*** is a version of *Stress First Aid (SFA)* that has been adapted for fire service use with civilian applications. It reduces distress, fosters adaptive functioning and makes people feel cared for and respected. By using these basic skills every day to help the people we serve, ***Curbside Manner*** prepares firefighters to automatically apply those same skills to our interactions with one another when a major event takes place.

***Stress First Aid*** is a peer-to-peer model that aims to reduce distress, foster adaptive functioning, provide tangible organizational support and increase the individual’s sense of competence and confidence. ***Stress First Aid*** was adapted from the *Combat Operations Stress First Aid* model used by Marines Corps and Navy personnel. It recognizes that one size does not fit all, that not everyone is equally affected by any given event and that not everyone needs the same things to help them through the stresses that come with fulfilling their mission. ***Stress First Aid*** assessment is designed to be an embedded function that is initiated by peers when they observe a change in functioning, hear statements of internal distress or in the event of a known stress exposure.

***Peer Program Guidelines*** are being developed to help identify and disseminate best practices, standards and objectives for peer support programs, utilizing a model derived from an international consensus project conducted by Australian Centre for Post Traumatic Mental Health. These will help augment ***Stress First Aid*** training for organizations desiring to take a more structured approach.

***Trauma Screening Questionnaire*** is an internationally recognized, evidence-supported tool that anyone can use three to four weeks after the impact of a PTE as a quick check to see if they should seek additional help. Questions pertain to arousal states and re-experiencing of the trauma surrounding the event; if any six of the ten symptoms listed have been experienced twice or more in past week, the individual should be referred for a full evaluation by a qualified clinician.

***Behavior Health Assistance Programs:*** changes to NFPA 1500 now specify the minimum levels of the types of services to be provided. A model template for fire departments to assist with developing *Request for Proposals (RFPs)*, a model template for potential vendors to assist with preparing proposals, and specific guidance for vendors in using FLSI 13 resources to build responsive BHAPs are being developed by the NFFF.

***Web-Based Training for Clinicians*** has been developed by the National Crime Victims Center at the Medical University of South Carolina to provide mental health professionals serving fire and EMS personnel with easily accessible, no-cost training in the best available approaches to evidence-based treatment. ***Cognitive Behavioral Therapy*** (CBT) using prolonged exposure techniques is firmly recognized as the best practice approach when significant intervention is indicated after a traumatic event but is rarely available at the levels of care that are typically accessible to firefighters. MUSC has applied its proven expertise in building such programs to create a version specifically designed for clinicians serving firefighters and EMS personnel.

**7. Is the new material equally applicable for firefighters and EMS staff?**

Yes. This model utilizes best-practice and evidence-based protocols that represent the highest standard of care available to emergency response personnel. The guided resiliency-building skills developed by After Action Review, Stress First Aid and Curbside Manner are equally applicable to all members of your staff, and will enable your department members to provide the
best possible care to members of your community, and to each other.

**8. My department has an existing CISM team. What role will this team have in the future?**

A wide range of authoritative guidelines agree that CISD should no longer be used. Though it has been a mainstay in our industry, substantial research has been conducted on its use in lessening the impacts of high-stress events and unbiased studies have repeatedly demonstrated that it is not effective in preventing clinical outcomes and, in some cases, can inhibit natural recovery.
FLSI 13 protocols were created by bringing together established researchers and fire service organizations to generate applications of the best available evidence-informed practices that could be integrated effectively into the structure and operations of fire and EMS agencies. The elements proposed represent their consensus agreement and the best practices currently available; the various component programs of FLSI 13 ensure that your organization can adopt them easily and
use them efficiently with little or no cost. The protocols developed are fully compliant with and reflective of all revisions to NFPA 1500.

Your CISM team can easily adopt the new skills and approaches provided in FLSI 13. Existing team members may be appropriate candidates for the peer support components of the program. Peers form a very important bridge between your firefighters and the behavioral health services that are available to members of your department and form an important element of the ***Stress First Aid*** approach included in FLSI 13.

**9. If my department decides to adopt the new model, how would we start?**

Your implementation plan should schedule trainings for all personnel in ***After Action Review*** and ***Curbside Manner***, which can be accomplished by downloading online Continuing Education packages or by having firefighters utilize the online learning presentations (see below). Training in ***Stress First Aid*** should initiated by enrolling an internal trainer in an NFFF Train-the-Trainer program or by identifying a trained trainer for your personnel. Materials to support these programs are available through *Everyone Goes Home®*. The NFFF is developing a comprehensive “***Guide to Firefighter Behavioral Health***” which will give fire departments a detailed outline of the entire FLSI 13 toolkit and timelines for adopting the new model.

**10. Will training be available? Where do I get it? What will it cost?**

Training in the component programs is available through the NFFF. After-Action Review and Curbside Manner trainings are now available. They are web-based, and free of cost to fire departments and individual firefighters. Support materials, including posters, cards and stickers are also available. Stress First Aid will be taught by trainers certified by the NFFF. Information
about all of these trainings is available on the FLSI 13 section of the www.lifesafetyinitiatives.org website.

**11. My department has a contract with a community EAP provider. What impact will the new model have on that service?**

It is important to note that within NFPA 1500 the designation of “EAP” (Employee Assistance Provider) has been changed to “BHAP” (Behavioral Assistance Provider), to eliminate the confusion between what services are being delivered and the way in which they are being delivered. It should also be clarified that BHAPs need not be an entity contracted by the department. In many cases, community, county or state mental health agencies may provide such services at reduced fees or without charge to emergency responders. Labor and employee organizations (such as union locals or firemen’s associations) may also sponsor or operate such programs. The key factor is that the specified services are available to firefighters and their families when needed, not how those services are contracted and delivered.

**12. Will I have to ask the EAP to change the way it conducts business with my fire/EMS personnel?**

NFPA 1500 establishes the minimum standards of types of services that should be available to members of your department. Changes that may be needed will vary according to what your current plan offers. In some cases, this could include significant changes in the range of services delivered by the BHAP; in other situations, departments may see little difference. To assist with the transition, the NFFF is developing a model template for fire departments to utilize in developing Request for Proposals (RFPs); a model template for potential vendors to assist with preparing proposals; and specific guidance for vendors in using FLSI 13 resources to build responsive BHAPs.

**13. How will local community clinicians get training on the new model? Will this training raise the price of my contract?**

Local clinicians will have access to FLSI 13 resources through the ***Helping Heroes*** portal. There they will find clinical assessment tools that have been specifically designed for assisting firefighters, and can enroll in web-based training for all component programs of FLSI 13. Most importantly, they will also be able to receive fire service-specific training in ***Trauma-Focused Cognitive Behavioral Therapy***, the state-of-the art protocol for dealing with depression, anxiety and other conditions. Therapists in your community can take this training online, free-of-charge, and receive continuing education units (CEUs) for it. This training should not affect the price of your contract.

**14. About how long should I expect to see results from the new model?**

Once fully implemented, you should see immediate results. FLSI 13 is about improving the way that firefighters deal with routine events so that they have the emotional skills to deal with the really difficult ones when they come along. Your personnel should be using ***After Action Review*** “*every time wheels roll*.” Likewise, they should be utilizing the skills in ***Curbside Manner*** in every civilian contact. These small changes in operational culture will yield big benefits in terms of fostering stronger, more emotionally resilient firefighters. They will also help you build a safer, more effective department and enhance your relationship with the citizens you serve.

**15. Were any fire chiefs or fire department EAP managers consulted as the new model was developed?**

Yes. Members of the major fire service organizations, EAP professionals, fire chiefs, fire officers and firefighters all provided input and guidance into the development of the FLSI 13 model. They collaborated with behavioral health scientists and academicians who had developed proven programs in other high-risk professions that could be applied to critical fire service needs, and together developed the FLSI 13 comprehensive protocol for firefighter behavioral health. This consensus process is very similar to those used to develop standards in medicine, the airline industry, the fire service and other professions.

**16. My department has chaplains. What will be their role moving into the future?**

Like peer teams, chaplains are critical in listening, reaching out and identifying individuals who may need assistance in dealing with personal, family or occupational stressors. In late 2012, the NFFF will be hosting a meeting with representatives of the various national chaplains’ organizations to educate them about the FLSI 13 behavioral health model and to collaboratively
define their role within the implementation of the protocol. Chaplains can begin to plan for the changeover by learning about the new program, scheduling trainings and discussing the changes with chief and company officers. Chaplains who were previously trained in other approaches will need to learn the differences and adapt their approaches accordingly.

**17. What about individual firefighters and EMS staff—what differences will they see when they seek behavioral health assistance?**

Firefighters and EMS personnel will see a new emphasis on how they relate to each other and to the civilians that they encounter in the course of their vocation. New operational procedures that mitigate negative behavioral health impacts will need to be integrated into every aspect of department operations. ***After Action Review*** teaches company officers to guide their team members through a “hot wash” analysis of every call. Firefighters learn to identify safety gaps that will reduce risk to themselves and to their team members, and to work cooperatively as a team. ***Curbside Manner*** teaches firefighters the basic skills of providing assistance to their customers in terms of dealing with the aftermath of a traumatic event. As a peer-delivered mechanism, ***Stress First Aid*** teaches firefighters to go to the next level, in terms of providing support to themselves, and to their team members. Firefighters who need additional help—whether they seek it out themselves or it is suggested by peers—will be treated by clinicians who understand fire service culture and have been trained to offer them therapeutic interventions that represent current standards of care.

**18. Will family services still be available?**

Yes. The guiding principle behind FLSI 13 is that both firefighters ***and*** their family members should have access to the best possible psychological care and counseling. Clearly, when a firefighter is suffering as a result of a work-related or personal problem, his or her entire family is negatively affected. Conversely, when another member of the family is having a difficult time, the firefighter’s performance and fitness for duty can be negatively impacted. NFPA 1500 standards state that BHAPs should have the capability to provide the following to both firefighters and their family members: *assessment*, *basic counseling and stress crisis intervention*, *regarding (at a minimum) alcohol and substance abuse*, *stress and anxiety*, *depression and personal problems*. They should also be able to provide referrals for appropriate clinical and specialty care services from providers equipped to deliver evidence-based treatment consistent with current best practices and standards

**19. Do we have to use the new model?**

Local jurisdictions retain the ultimate authority to govern their policies and procedures in this domain as in most others. The behavioral health model developed and supported through FLSI 13 is based on the consensus recommendations of both leading researchers (including representatives from such programs as the National Center for PTSD of the Veterans Administration, the Center for the Study of Traumatic Stress at the Uniformed Services University of Health Sciences, the National Crime Victims Research and Treatment Center at the Medical University of South Carolina, the National Institute for Occupational Health and Safety and the Employee Assistance Professionals Association) and leading fire service organizations (including the International Association of Fire Fighters, the International Association of Fire Chiefs, the National Volunteer Fire Council, the National Fire Protection Association, the North American Fire Training Directors and the National Association of Emergency Medical Services Physicians). It is fully consistent with all elements of both Chapter 11 (*Behavioral Health Assistance Program*) and Chapter 12 (*Occupational Exposure to Atypically Stressful Events*) of NFPA 1500 and with major authoritative guidelines regarding response to potentially traumatic events. Organizations are always advised to review all policies that impact the health and safety of their employees and to make these, wherever possible, as compliant as possible with prevailing guidance and standards. The FLSI 13 behavioral health model ensures that fire departments can achieve compliance, without undue difficulty or expense.