Responding to Potentially Traumatic Events (PTE's)

- First and foremost, remember it is a potentially traumatic event, not automatically traumatic.
- Just as we preplan for fire responses, we must preplan for PTE's. Do you know your crew (If not, start doing so). The best way to prevent PTSD and predict a positive response to a traumatic incident is resiliency before the event. Resiliency is built by our day-to-day coping skills and relationships.
- Was it the call or is it cumulative? Is there something else impacting their individual response to the event?
- Initially after a PTE, we should help to normalize and validate stress response
    - It is a normal reaction to abnormal event.
    - Not all people respond the same.
    - Some are not impacted at all.
    - Sometimes, minor events cause seemingly disproportion responses (straw that broke the camel's back).

Optional on-scene observation:

Limit exposure of Chaplain/Peer members at the scene. Therefore, send one at max two members to the scene for an initial assessment. Peer support personnel respond to the scene as observers and advisers to watch for the development of acute reactions. They may offer encouragement and support, check on the well-being of personnel, and allow for individual discussion of feelings and reaction.

Crew Returns to Station:

- Maslow's Hierarchy of needs:
    - What do they need? Food, Shower, Water, Sleep ETC?
    - Do they need to call home?
- Educate Healthy Expressions of Emotions:
    - Expressing emotions is an important part of healing (verbally / journaling).
    - REM sleep is necessary for processing traumatic events.
    - Alcohol inhibits REM sleep.
    - It's ok to not be ok.
    - It's ok if it doesn't bother you at all.
- Allow opportunity for crew to voice opinion (defuse) with each other.
- Firefighters generally have greater support structures within their stations and crews. However, they can become vulnerable when they suffer from poor sleep, work-family conflict, transfer, ostracism, or a significant loss.
- If the crew is tight, they are their best resource. If there is poor leadership or conflict, peer or chaplain can be helpful.
    - If not needed right away, that's ok, offer resources as needed and when needed.
    - Use best judgement based on the individual situation and the individuals involved.
    - Again, know your crew and be open to listening to their needs.

- If they are not receptive, remember, events are potentially traumatic and not automatically traumatic.
- Overall, make it safe for individuals to talk by creating an open and supportive environment that can allow that person, crew, etc to feel supported, understood and that they can make some choices.
- ***Choice has significant power post event.***
- If they are not struggling, allow them the space to be "ok" as not everyone is going to experience the same event in the same way.
- The first few calls after an incident can feel "shaky," do not threaten their confidence. With time, their ability returns.

Administration

It is important for admin to check in on members, offer support, and create an open-door policy post event. However, admin should not come in until after the defusing. At times, Admin can plant a seed in the back of the responder's mind that they may be listening in the next room or are just checking a box. Once the defusing is over and we've identified a member which may need to go home, then we should brief admin on their departure outside the defusing room. Then the admin comes in to share their wisdom to the group. Firefighters appreciate support from admin, but struggle to show vulnerability with admin present.

Initial Defusing:

If the event was significant enough (Working Pediatric Cardiac Arrest /Working Expectant Mother Cardiac Arrest, etc), an initial defusing can be a helpful way to help educate the responders on their possible feelings, responses, and healthy ways to manage stress. Defusing's and one-on-one conversations are generally helpful for 80% of potentially traumatic events. They are less formal than a debriefing, usually lasting no longer than 1 hour, without a critique of the incident.

- The purpose is to offer information, support, and to allow for initial ventilation of thoughts and feelings.
- Timeline – Provided usually within 3-6 hours of the incident.
- Process – May be initiated automatically due to nature of incident or voluntarily at the request of the company officer.

Studies have shown that prompt effective stress management the day of an event help to tremendously lessen the stress reactions. That is why on duty trained personnel are so important. When possible, it is also helpful to have dispatchers and EMS involved in the defusings. Having all parties involved in the incident there will allow all the pieces of the critical incident puzzle to create a whole picture. Having the finished picture will allow for firefighters to process their emotions related to the incident.

By providing prompt stress management utilizing defusing's and one-on-ones, it is possible to alleviate the amount of PTS in individuals after critical incidents.

Formal Debriefing

Critical Incident Stress "Debriefings" are no longer the primary component of CISM programs. Today, an effective program utilizes an integrated, multi component approach, with the primary focus on "Defusing's" and "One-on-One Interventions." "Formal Debriefings" are used when the personnel have faced a disaster or large-scale incident. Some examples include:

- Mass Casualty Incident (MCI) or incident involving multiple fatalities not marked as a MCI.
- Line of Duty Death
- Line of Duty Serious Injury
- Mayday

A Formal Debriefing is a 7-phase, group discussion based on the model developed by Dr. Jeff Mitchell (Evidence based research has found it can be just as harmful as helpful and should never be mandated).

- The debriefing is a confidential discussion of the involvement, thought, and reaction resulting from the incident. It is not a critique of the operational aspects of the incident.
- It is designed to mitigate acute symptoms, assess the need for follow-up, and when possible, to provide a sense of psychological closure to the incident.
- Timeline – It is most effective when conducted within 24 to 72 hours of the incident.
- Process – May be initiated automatically or voluntarily. If the incident resulted in the loss of a member to the department, it should be conducted by an outside CISM team (NCLEAP/CARY Fire, etc).

Member feels they Can Not continue at work:

If a member expresses that they just need to be home with their family, this may simply be their individual need. Sometimes, people need to be with their loved ones after an event.

When a peer team sits with a firefighter, we should always encourage them to return to duty, **UNLESS**, they feel unsafe or that they are unable to complete one of the 14 essential job tasks in NFPA 1582.

1. Wearing personal protective equipment (PPE) and self-contained breathing apparatus (SCBA) while performing firefighting tasks (e.g., hose line operations, extensive crawling, lifting and carrying heavy objects, ventilating roofs or walls using power or hand tools, forcible entry), rescue operations, and other emergency response actions under stressful conditions, including working in extremely hot or cold environments for prolonged time periods
2. Wearing an SCBA, which includes a demand-valve-type positive-pressure facepiece or HEPA filter mask, which requires the ability to tolerate increased respiratory workloads
3. Exposure to toxic fumes, irritants, particulates, biological (i.e., infectious) and nonbiological hazards, or heated gases, despite the use of PPE and SCBA
4. Climbing at least six flights of stairs or walking a similarly strenuous distance and incline in jurisdictions without tall buildings while wearing PPE and SCBA, commonly weighing 40–50 lb (18–23 kg) and carrying equipment/tools weighing an additional 20–40 lb (9–18 kg)
5. Wearing PPE and SCBA that is encapsulating and insulated, which will result in significant fluid loss that frequently progresses to clinical dehydration and can elevate core temperature to levels exceeding 102.2°F (39°C)

6. Working alone while wearing PPE and SCBA, searching, finding, and rescue-dragging or carrying victims ranging from newborns to adults weighing over 165 lb (75 kg) to safety despite hazardous conditions and low visibility
7. While wearing PPE and SCBA, advancing water-filled hose lines up to 1 3⁄4 in. (45 mm) in diameter from fire apparatus to occupancy [approximately 150 ft (50 m)], which can involve negotiating multiple flights of stairs, ladders, and other obstacles
8. While wearing PPE and SCBA, climbing ladders, operating from heights, walking or crawling in the dark along narrow and uneven surfaces that might be wet or icy, and operating in proximity to electrical power lines or other hazards
9. Unpredictable, prolonged periods of extreme physical exertion as required by emergency operations without benefit of a warm-up period, scheduled rest periods, meals, access to medication(s), or hydration
10. Operating fire apparatus or other vehicles in an emergency mode with emergency lights and sirens
11. Critical, time-sensitive, complex problem solving during physical exertion in stressful, hazardous environments, including hot, dark, tightly enclosed spaces, that is further aggravated by fatigue, flashing lights, sirens, and other distractions
12. Ability to communicate (i.e., give and comprehend verbal orders) while wearing PPE and SCBA under conditions of high background noise, poor visibility, and drenching from hose lines or fixed protection systems (e.g., sprinklers)
13. Functioning as an integral component of a team, where sudden incapacitation of a member can result in mission failure or in risk of injury or death to members of the public or other team members
14. Working in shifts, including during nighttime, that can extend beyond 12 hours

If a member goes home because they do not feel they can continue at work, they should receive referral resources, and connect with a clinician within 48hrs. This can include Raleigh Police Psychologist, EAP, an NCPS vetted clinician, or their own clinician. This appointment is not a fit for duty evaluation, but rather an opportunity to connect with a professional.

If the member goes home, in addition to the Company Officer following up, we should have a peer team member follow-up. We've found the member will generally talk to either the CO or the peer team member. Some members don't want their CO to see their vulnerabilities. Some CO's will mock or discount the members emotions and feelings.

Our mandatory referral process to EAP will be utilized if the member meets the criteria for mandatory referral and should be avoided in response to potentially traumatic events. (Unless member is exhibiting dangerous behavior).

One-on-One Peer Support

A couple of one-on-one meetings with a peer can help alleviate a lot of the stress reactions in those individuals that respond to a critical incident. Peers can empathize with other peers in a way that clinicians can't. If necessary, a peer should meet with an individual at the most three to four times. If an individual hasn't gotten relief from the critical incident in those three to four sessions, then it's time to

get them support from a clinician. Social support and self-care are some of the most important factors for overcoming traumatic experiences. Firefighter networks and crews can help aid and support affected members need to adapt and overcome. Other protective factors against negative outcomes found in the literature are humor, journaling, sleep, and empathic listening with peers and supervisors.

One-On-One Intervention

One-on-One Crisis Intervention or psychological support is available to members who have been affected by a critical incident.

- The intervention is conducted by a Mental Health professional.
- Sessions are confidential and are usually scheduled during the employee's off-duty time.
- The goal is to mitigate acute symptoms and assess the need for referrals and follow-up.
- Timeline – At the employee's discretion.
- Process – May be initiated voluntarily by employee or through Company Officer at employees request. Resources include NCPS vetted Clinicians, Behavioral Health Solutions, or RPD Psychologist (see attachment of resources at end).

Provide Optional Clinical Resources:

"It is important to remember that what works for one person might not work for everyone. It is also important to realize when symptoms are severe enough that they need to be handled by someone outside the department. There are limits to what peers can provide in terms of support. And when that limit is reached, the most supportive thing a firefighter can do is be willing to help their brother or sister find the right help." – Janke, S.A. 2015

- When given the choice, individuals are more likely to be honest and transparent when utilizing clinical resources.
- When they feel like they are being evaluated, they tend to share what they think will get them cleared to return to duty.

100% Confidential Resources available for our members:

- RFD Chaplain, Jeff Neal, (919)353-3839
- Raleigh Behavioral Health Solutions (EAP) 800-327-2251
- Raleigh Police Psychologist Dr. Julanne Erickson (919) 815-9455
- North Carolina Peer Support 1-855-7NC-PEER / ncffps.org (This number will provide access to Raleigh Peer Support members, Peers unaffiliated with Raleigh, and a list of vetted culturally competent clinicians).

Different People Respond Differently to PTE's.

- Priority 1 – Extreme Condition: The individual is in distress due to being extremely affected. The Team Member should follow up daily until priority is changed or the individual no longer wishes to be contacted. If the Team Member determines the individual may need follow-up with a team clinician, see "Referral to Clinician below).

- Priority 2- Guarded Condition: The individual was seriously affected. Follow-up should be made by the team member every 2-3 days until priority is changed or the individual no longer wishes to be contacted.

- Priority 3 – Monitored Condition: The individual was somewhat affected and needs minimal attention. The team member should follow up weekly until the priority is changed or the individual no longer wants to be contacted.

- Priority 0 – Strike: The individual no longer needs contact or no longer wishes to be contacted.

******Keep in mind the need for choice after a traumatic event. Trauma occurs when choice is taken away from an individual. Care should be taken to ensure the individual knows that they are in ultimate control of healing from an incident. We should never force an individual to open when they are not ready or not willing. ******

Citations:

A., V. der K. B. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. Viking.

Junger, S. (2017). Tribe. Fourth Estate Ltd.

https://www.ems1.com/mental-health/articles/rethinking-critical-incident-debriefings-pXBGurJ9hjKqdpD1/

https://www.blueline.ca/psychological-debriefing-are-we-doing-more-harm-than-good-6321/

Raleigh Fire Department Peer Support Team:

North Carolina First Responder Peer Support's (NCFRPS) mission is to recognize that all fire service, law enforcement, and emergency medical service personnel are human beings who will be exposed to, and experience emotions. NCFFPS will provide a safe, non-judgmental and confidential environment where members can engage in a healing conversation with a peer. NCFRPS is a 501(3)(c) nonprofit that can provide financial assistance for members seeking mental health counselling.

Raleigh Chaplain: 919 353-3839

If you need support, no matter the issue, please reach out: 1-855-7NC-PEER / ncffps.org

Behavioral Health Solutions (EAP): 1-800-327-2251

Raleigh Fire Team Members:

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Brian McGinnis (919) 710-3372	Brantly Hobbs (919) 306-0561
Bryan Kilmer (919) 427-0182	Clay Hicks (919) 291-3206
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Greg Ceisner (919) 796-9830	Hannah Canterbury (919) 333-68443
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John Sealey (919) 279-7881	Johnny Brown. (919)669-8813
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