THE INTERAGENCY BOARD

November 2014

Stress-Related Mental Health Issues in Emergency Responders, First Receivers, Disaster Workers, and Their Families

PROBLEM/ISSUE

There is a need for improved operational approaches to the detection of stress and mitigation of stress-induced mental health disorders in emergency responders and disaster workers. Currently, there are no government lead agencies or established standards that provide guidelines on proposed departmental methods for mental health and behavioral intervention programs. In the coming years, as veterans return from recent wars, there is likely to be an increase in persons with new or exacerbated mental health disorders. Many of these veterans will be joining the emergency services sector and thus departments and agencies should be aware that these individuals may have higher incidences of stress-related issues.

BACKGROUND

For decades it has been recognized that the unique and often stressful responsibilities and challenges faced by emergency responders and disaster workers may place them at a significantly higher risk of developing symptoms of psychological stress. This stress can result in a wide spectrum of short and long-term behavioral and mental health issues that can affect the operational readiness of both the individual and the organization where they are employed. Additionally, these stresses can have a significant impact on their private lives and relationships, potentially resulting in subsequent impact to their spouses, children and other close relatives or contacts.

DISCUSSION

In the past, individuals and organizations have provided psychological assistance to emergency responders and disaster workers to the best of their ability, but without much valid research to support their approaches or techniques. Since the 1990s, many organizations have incorporated variations of Critical Incident Stress Management (CISM)[1]. Although CISM is still used in some emergency and disaster response communities, fundamental questions regarding its safety and efficacy have been raised.

Many responders have reported that they benefited through participation in CISM; however, research has shown the method has significant limitations. There are concerns that those least exposed to significant incident-related trauma may actually experience further trauma during group debriefings. Furthermore, this research did not reveal an appreciable preventative effect. In fact, it suggested that those most severely affected by an incident might have more difficulty resolving their reactions as a result of their participation in these interventions. Authoritative guidelines for early interventions

following exposure to traumatic events now recommend against routine debriefing or other procedures incorporating debriefing-like approaches.[2, 3]

In an effort to address the perceived limitations of the CISM model and achieve better acute and long term outcomes for those traumatized by psychological stresses, various stress management method for stabilizing or inoculating behavioral and mental health have been and are being tested in civilian and military environments. [4] Promising research that identifies the neural pathways through which psychological stress is processed that indicates more effective strategies may be identified and developed. This research distinguishes common issues and concerns that should be considered. It has shown that enhanced individual resiliency should be pursued through early identification of those at greatest risk for long-term complications along with effective, individualized, and tiered interventions. [5, 6]

This emerging research and practice emphasizes the neuroplasticity of the human brain. It demonstrates the effectiveness of individuals and organizations facilitating work-related stressors. The focus should be on psychological growth and resiliency rather than on persistent disorders. [7, 8] A thorough analysis of best or promising practices should be combined with the quickly growing database of research related to psychological resilience, cognitive behavioral therapy, and mindfulness to address the behavior and mental health resilience needs of the nation's emergency responders and disaster workers. However, emergency response personnel should not serve as the test-bed for unproven stress- control related interventions and inoculations, unless they agree beforehand to participate in well-designed and IRB-approved clinical studies.

RECOMMENDATIONS

The Health, Medical & Responder Safety (HMRS) Subgroup of the Interagency Board recommends the following:

1. Emergency response departments, agencies and organizations must provide access to behavioral and mental health programs for their responders and receivers, and their immediate family members, whenever needed. These programs must include basic counseling, crisis intervention assistance, and triage. They should incorporate assessments regarding, at a minimum, alcohol and substance abuse, stress and anxiety, depression, and personal problems that may adversely affect emergency responders' work performance. The program must, when clinically indicated, refer emergency responders or their immediate family members to appropriate clinical and specialty care providers trained to deliver effective evidence-based treatment consistent with current best practices and standards for behavioral and mental health care and treatment.

2. Emergency response departments and organizations must adopt and follow clear, written policies regarding substance abuse and other negative coping behavioral and mental health conditions.

3. The behavioral and mental health program of an emergency response department or organization must address occupationally-derived exposures that could be associated with acute or chronic behavioral changes or exacerbate a pre-existing behavioral or mental health disorders. The emergency response department or organization must enact a policy that minimally specifies:

    a. Specific criteria for initiating referral to the program,
    b. Employee assistance program offerings and interventions available to affected personnel,
    c. That participation in the program and any clinical interventions is voluntary, and
    d. Where specialty treatment is indicated based on behavioral and mental health assessments, there will be referral to licensed and certified specialists (e.g., psychiatrist, psychologist, licensed clinical social workers) credentialed and licensed to provide evidence-based treatments consistent with current best practices and standards of care.

4. Emergency response departments or organizations and their behavioral health programs must adopt and follow clear, written policies consistent with applicable statutes, regulations, confidentiality, data gathering, reporting, and protection with regard to the release of personally identifiable information (PII).

5. Behavioral health programs of emergency response departments and organizations should be aware of Department of Defense, Veterans Affairs, American Red Cross, and other federal initiatives relevant to stress detection, triage, and treatment of post traumatic stress disorders and stress-induced behavioral and mental health conditions.

6. Adequate federal resources must be dedicated to catalog and disseminate what is currently known regarding the prevention and mitigation of psychological stress among emergency responders and disaster workers. There must be federal support for a national research program to collect, evaluate, compare and promote psychologically-based interventions and best practices to encourage behavioral and mental health resilience in emergency responders and disaster workers.

**Please contact the InterAgency at info@interagencyboard.us with any comments, feedback, and questions. Additional information on the InterAgency Board is available at www.IAB.gov.

---

[1]U.S. Department of Health & Human Services, "Critical Incident Stress Management". (Available at http://www.foh.dhhs.gov/NYCU/CISMInfo.asp)

[2]National Institute of Mental Health, "Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence", (2002). (Available at http://www.nimh.nih.gov/health/publications/massviolence.pdf)

[3]National Collaborating Centre for Mental Health and the National Institute for Clinical Excellence, "The management of PTSD for adults and children in primary and secondary care", (2005). (Available at http://www.nice.org.uk/guidance/cg26/resources/cg26-posttraumatic-stress-disorder-ptsd-full-guideline-including-appendices-1132)

[4]National Registry of Evidence-based Programs and Practices, "Transtheoretical Model-Based Stress Management Program", (October 2007). (Available at http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=32)

[5]Brewin, C.R., Fuchkan, N., Huntley, Z., Robertson, M., Thompson, M., Scragg, P., d'Ardenne, P., and Ehlers, A. Outreach and screening following the 2005 London bombings: usage and outcomes. *Psychol Med*. 2010 Dec 40(12):2049-57.

[6]Shalev, A.Y., Ankri, Y., Israeli-Shalev, Y., Paleg, T., Adessky, R., and Freedman, S. Prevention of posttraumatic stress disorder by early treatment: results from the Jerusalem Trauma Outreach and Prevention study. Arch Gen Psychiatry. 2012 Feb 69(2): 166-76.

[7]A Developing Capabilities for Enhancing Responder Resilience Challenges", Merritt Schreiber, PhD: In "Proceedings of the Community Health Resilience Workshop 2011"
US Department of Homeland Security and US Department of Health and Human Services, February 2012.

[8]PsySTART Rapid Mental Health Triage and Incident Management System (Available At http://www.cdms.uci.edu/PDF/PsySTART-cdms02142012.pdf)