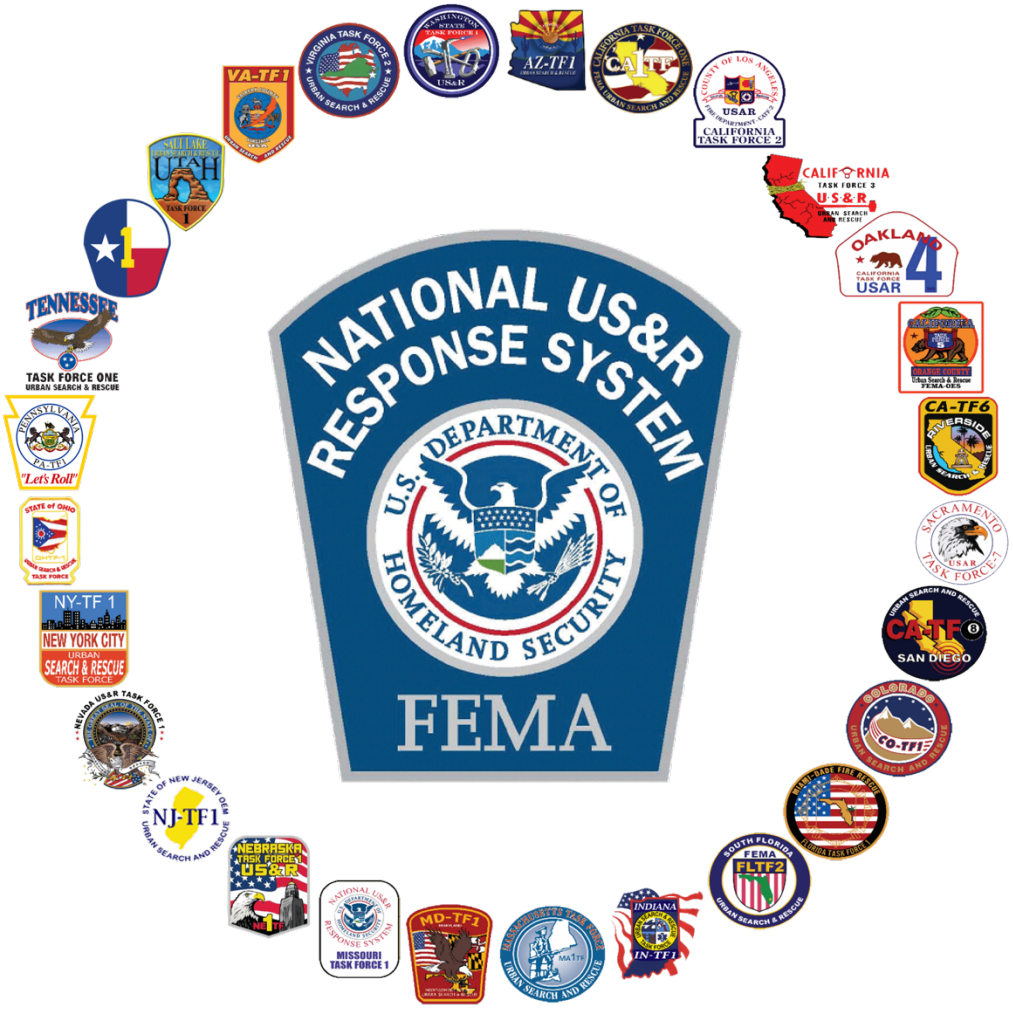
National Urban Search and Rescue System

Behavioral Health Ad Hoc

Recommendations to the Advisory Group

March 2025



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Section 1- Background

In May of 2024, the National Urban Search and Rescue System seated an ad hoc group to the broader Advisory Group to examine and address the System's behavioral health needs. The group selected has broad representation from the divisions (East, Central, West).

Name	Affiliation	Name	Affiliation
Bormann, Christy	TX-TF1(Central)	Strote, Jared	WA-TF1 (West)
Boyle, Mike	CA-TF5 (West)	Wang, Qing	IN-TF1 (Central)
Grossman, Marc	MA-TF1 (East)	Wilt, Bradley	MD-TF1 (East)
Windell, Jacob	CA-TF2 (West)		
Co-Chair: Fossum, Bret	UT-TF1 (Central)	Co-Chair: Macintyre, Anthony	FEMA

Simultaneous to the seating of the ad hoc, an interim plan to address behavioral health needs was established by the US&R Branch. This was sent out as US&R GM 2024-25 and is attached as **ATTACHMENT A**. This was designed to bridge operational requirements pending outputs from the Behavioral Health Ad Hoc.

In summary, the Behavioral Health Ad Hoc was charged with the following:

- Identify behavioral health requirements for the System
- Develop:
  - Response models
  - Associated policies and procedures
  - Associated training
  - To include post-deployment support

The co-chairs of the ad hoc provided the following as guidance to the members of the group. All proposed solutions must:

- Have proven value in preventing or addressing behavioral health needs
- Must be fully integrated into US&R procedures (and hence, most solutions should come from within the US&R System)
- Must not negatively impact US&R operations
- Must be feasible and easily implemented

Finally, the Behavioral Health Ad Hoc members were acutely aware of budgetary constraints the System faces. For that reason, few requirements are proposed. Instead, a method of growing organic internal capability has been designed – one that may take time to fully implement.

The recommendations are attached to this document and are designed to address all phases of US&R response (preparedness, mobilization, operations, demobilization, return to readiness).

This document is separated into several sections. Section 1 is the background information. Section 2 is the proposed requirements for the US&R System. Section 3 is the recommendations for implementation within the US&R System. Section 4 is the conclusion and final comments.

Section 2- Proposed Requirements for the US&R System

Recommendation 1 to the Advisory Group - Pre-Deployment (Pre-incident)

Recommendation: Personal resiliency training as a requirement

- All System members shall have training on personal resiliency. **This is a new proposed System requirement.**
- The training is designed to inform System members of the unique stressors that exist in the US&R operational environment and associated coping measures.
- The intent is that by being aware of these issues prospectively, before deployment, individuals will be able to recognize signs and symptoms of stress in themselves and others - to address them more effectively.
- Ad Hoc members recognize that some Sponsoring Agencies/Participating Agencies already provide training sessions that address these topics for Task Force members.
- To provide consistency in approach across Task Forces and to ensure that uniformed and civilian members all have this basic information, the requirement is for all System members to take the newly developed "US&R Personal Resiliency Training" developed by the Behavioral Health Ad Hoc.
- This training will be offered on the LMS with a voice over requiring approximately one hour to complete.
- Alternatively, Task Forces are encouraged to provide the training in person with their own instructors to permit question and answers from students.
- This training should be offered at the time of onboarding with the Task Force and existing members may take the course in accordance with Task Force scheduling.
- This is a one-time requirement for each System member. It is recommended that this topic becomes part of annual training/refresher for System members.
- It is anticipated that this requirement should take 18 months to implement (fully integrated at the task force level by Jan 1, 2027).
- This requirement will be included in Administrative Readiness Evaluations (AREs) checklists.

Recommendation 2 to the Advisory Group - Tiered Response for Incident Needs (Incident)

Recommendation: The National US&R System should adopt a tiered approach to addressing System behavioral health needs during incident operations. As incident complexities increase, higher levels of support may be required.

- US&R operations vary significantly between different incidents. As such, the behavioral health support for teams is most efficiently addressed in a flexible and tiered manner increasing with higher levels of complexity as required and as dictated by the incident.

- A priority for this flexible system is to rely on internal resources, or resources from organizations similar to the System, in order to promote greater adoption by those seeking to use this resource.

- **It is proposed that the following tiered System be adopted by the System as formal policy in how to address behavioral health needs during deployments.**

- If a Sponsoring or Participating Agency has a PSP program, it is encouraged to anticipate any needs, and to deploy dual-role Peer Support Providers (PSPs) with the deployed number dependent on the Typed Resource (Type 1, Type 3, MRP, etc.).

- Each tier is further explained below:

Tiered Behavioral Health Support for Deployed US&R Resources	
Utilization of Resources Already Deployed	
1	Medical Team on deployed US&R Resource is able to address behavioral health issues
2a	PSP deployed with US&R Resource is able to address behavioral health issues
2b	PSPs deployed with other US&R task forces are shared with other task forces in a time-limited fashion (based on IST coordination and donating TF TFL approval)
3	AHJ has public-safety based resources that are already deployed and assessed as appropriate to utilize for deployed US&R Resources
Additional Resources Required/Requested	
4a	US&R Resource requests augmentation with PSPs from their own task force (request process through IST) - based on a single task force need
4b	IST determines need for broader deployed support and requests deployment of "US&R PSP Response Package." Examples include: • As in 2b, no PSPs available to assist sister TF deployed • Broader support for System is determined.
5	IST requests external resources to deploy and assist US&R Resources – specifically the International Association of Firefighters (IAFF) Behavioral Health Support Team.
Outlier/Special Circumstances	
6	A rare, specialized circumstance (such as Incident Within an Incident or IWI) in which PSPs or other behavioral health support from the Sponsoring/Participating Agency is requested and coordinated through the IST and Branch.

- **Tier 1:** Medical Team on deployed US&R Resource is able to address behavioral health issues:
    - Medical Team Managers and Medical Specialists that have deployed with the team are

anticipated to be able to address many, basic behavioral health needs. Some Medical Teams already do this either formally or informally for their respective Task Forces.
    - Most should be able to address acute crises as well.
    - This capability will be enhanced if recommendation 5 by the Behavioral Health ad hoc is adopted by the Task Force (Offering PSP training to MTMs).

- **Tier 2a:** PSP deployed with US&R Resource is able to address behavioral health issues
    - Almost every System task force (TF) has trained Peer Support Providers (PSPs) that serve in a variety of operational positions.
    - TFs are not required to deploy PSPs in a dual-hatted role, but they are encouraged to do so.
    - Those that are deployed will be tracked by the IST.
    - An existing section in the Team Fact Sheet will be filled out by deploying System resources:
        - This section will query how many of the personnel being deployed have recognized PSP training or are currently a member of their organization's peer support team.
    - This information will be monitored by the Incident Support Team (IST) Medical Officer (MOFR) and utilized in two ways:
        - To identify deployed System resources which may require more behavioral health support (i.e., few to no PSPs deployed).
        - To identify PSPs in the field that could be asked to assist another System resource if support is needed (see Tier 2b).
    - PSPs deployed in this capacity should follow their relevant Sponsoring or Participating Agency's protocols.
    - Credentialling of a System member as a PSP for these purposes is entirely based on the Sponsoring or Participating Agency criteria. However, the PSP should be an active member in the Sponsoring or Participating Agency's PSP program.

- **Tier 2b**: PSPs deployed with other US&R task forces are shared with other task forces in a time-limited fashion (based on IST coordination and donating TF TFL approval).
    - The IST may be requested to coordinate PSPs deploying with one TF to assist another TF.
    - This is expected to be a time limited function and will only occur with the approval of the donating TF Leader.
    - The PSP should be an active member in the Sponsoring or Participating Agency's PSP program.
    - Unlike Tier 2a, the PSP to be utilized must have had one of the following acceptable trainings:
        - International Association of Firefighters – Peer Support training
        - University of Central Florida Restores: Recognize. Evaluate. Advocate. Coordinate. Track (REACT)
        - Boulder Crest: Struggle Well
        - International Critical Incident Stress Foundation (ICISF): Group Crisis Intervention and Assisting Individuals in Crisis
        - Texas Engineering Extension (TEEX): Support that Saves

- **Tier 3:** AHJ has public-safety based resources that are already deployed and assessed as appropriate to utilize for deployed US&R Resources
    - In some instances, the AHJ will have deployed a public safety based behavioral health resource.

- Access to this resource may be offered by the AHJ as a courtesy to federal US&R teams.
- The IST Medical Officer should assess this resource to ensure it is an appropriate resource prior to utilization by federal US&R teams.
- In addition, the IST Medical Officer should assess the capacity of the services offered to ensure adequacy for anticipated System need.

- **Tier 4a:** US&R Resource requests augmentation with PSPs from their own task force (request process through IST) - based on a single task force need.
  - In select circumstances, a deployed Task Force can request through the IST, deployment of PSPs from their Sponsoring or Participating Agency. This request should be accompanied with justification for the deployment of additional personnel (anticipated to be usually 2 PSPs and a minimum of 2 PSPs).
    - In even rarer circumstances, this request may occur during mobilization and the Branch will decide at the time of deployment if conditions warrant approving the request.
  - For costs incurred to be reimbursed, this must be approved by the IST.
  - PSPs deployed to serve exclusively in this role must be National US&R System Members
  - Credentialling of a System member as a PSP for these purposes is entirely based on the Sponsoring or Participating Agency criteria. However, the PSP should be an active member in the Sponsoring or Participating Agency's PSP program.
  - PSPs deployed in this capacity should follow their relevant Sponsoring or Participating Agency's PSP protocols.
  - The requesting TF is responsible for the oversight, deployment, sustainment, and demobilization of the PSP resources sent.

- **Tier 4b**: IST determines need for broader deployed support and requests deployment of "US&R PSP Response Package."
  - If deployed resources are not sufficient, the IST may determine that additional System resources are required. For example:
    - Tier 2 b is not an option due to lack of deployed PSPs or outstripping the capabilities of the deployed PSPs.
    - A broader System requirement is determined by the IST
  - The IST Medical Officer will work with the IST Safety Officer and IST Leader to craft a request with justification to the ESF 9 Group Supervisor.
  - A new capability, the PSP Response Package (see recommendation 7 for more detail) will be deployed with approval.
  - This capability is considered an IST asset and is under the direction of the IST.
  - It may be deployed centrally (i.e., at a single location) or members may be deployed to reach out in pairs to geographically dispersed Task Forces.

- **Tier 5:** IST requests external resources to deploy and assist US&R Resources – specifically the International Association of Firefighters (IAFF) Behavioral Health Support Team.

- As a final back stop, to support Behavioral Health needs for the deployed System, the Behavioral Health Ad Hoc is recommending that FEMA establish a capability to deploy the IAFF Behavioral Health Support Team, in extreme circumstances, to support the needs of the System.
- The System has evaluated this resource in real-time operations in the past, and is aware of no other similar resource that meets the identified needs of System members.
- Not only are the personnel public safety based, but their procedures are consistent with the needs of the System.
- Finally, they are self-sustaining during field operations and would be anticipated to have minimal impact on US&R operations.

- **Tier 6**: This is anticipated to be a rare event and not often utilized (e.g. a Major Event Review Team [MERT] activation).
  - In the event of a near-miss, significant injury, or fatality, the home unit may choose to send their own, internal peer support resources.
  - This will generally be sent from home agency with either System or non-System PSPs that deploy to meet the needs of the deployed task force.
  - Although coordination is recommended with the IST, at a minimum coordination will occur with the US&R Branch and the IST will receive notification of the deployed resources for awareness.
  - The IST may be called upon to provide logistical support to the deployed members.

Recommendation 3 to the Advisory Group - PSP Response Package (Incident)

Recommendation: The National US&R System should develop a capability to deploy PSP providers from the System as a response package to support operations when requested by the IST.

- Consistent with the 4b tier of supporting Behavioral Health needs of System resources, it is recommended that the System develop the capability to deploy PSP providers.

Tiered Behavioral Health Support for Deployed US&R Resources	
Utilization of Resources Already Deployed	
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Additional Resources Required/Requested	
4a	US&R Resource requests augmentation with PSPs from their own task force (request process through IST) - based on a single task force need
4b	**IST determines need for broader deployed support and requests deployment of "US&R PSP Response Package." Examples include:** • **As in 2b, no PSPs available to assist sister TF deployed** • **Broader support for System is determined.**
5	IST requests external resources to deploy and assist US&R Resources – specifically the International Association of Firefighters (IAFF) Behavioral Health Support Team.
Outlier/Special Circumstances	
6	A rare, specialized circumstance (such as Incident Within an Incident or IWI) in which PSPs or other behavioral health support from the Sponsoring/Participating Agency is requested and coordinated through the IST and Branch.

- These PSP providers would be comprised of System members.

- The below provides a general program description.

    - As part of a tiered system, the US&R Branch will maintain a list of System personnel who may be requested by the Incident Support Team (IST) to deploy to support Behavioral Health needs of the System during response operations. PSP's provide emotional support and assistance to System members in times of stress or crisis, while on deployment.

- These personnel will be deployed, with the concurrence of their Sponsoring Agency, and report to the IST Medical Officer for assignment in the field. They will work as part of a "PSP Response Package." For safety and accountability, the smallest configuration of a PSP Response Package will be two PSP providers. Their logistical and administrative requirements will be addressed by the IST. They are considered IST resources, and therefore, must have completed IST New Member Orientation Training (in person) prior to deployment. During program implementation, a virtual IST New Member Training is acceptable.

- Personnel Requirements:
  - Individuals selected to serve in this role must:
    - Be recognized as a Peer Support Provider by their Sponsoring/Participating Agency.
    - Be active and in good standing with their Sponsoring/Participating Agency's Peer Support Program.
    - Rostered member of their TF for a minimum of 5 years, with deployment experience highly recommended.
    - Have completed IST New Member Orientation training (see above).
    - Have completed one of the following courses:
      - International Association of Firefighters (IAFF) – Peer Support Training
      - University of Central Florida Restores – Recognize, Evaluate, Advocate, Coordinate, Track (REACT)
      - Boulder Crest – Struggle Well
      - International Critical Incident Stress Foundation (ICISF)- Group Crisis Intervention and Assisting Individuals in Crisis.
      - Texas Engineering Extension (TEEX) – Support that Saves
    - Individuals will be selected to serve in this role through the regular IST selection and onboarding process.
    - The list of personnel available to deploy will be maintained by the US&R Branch in coordination with the Advisory Organization.

- Organizational constructs:
  - The PSP Response Package deploys at the request of the IST and concurrence of the Branch.
  - PSP's can deploy as a single resource out of their TF but will never serve as a single resource operationally. They will operate in teams consisting of a minimum of two PSPs.
  - A PSP Strike Team consists of 4 PSPs, generally with one Division/Group Supervisor (DIVS) per Strike Team.
    - Span of control can fluctuate based on geographic area, co-located work area, or mission assignments.
    - The DIVS must be a qualified DIVS but may not have PSP training.

- The PSP Response Package and/or PSP DIVS will generally report to the IST Medical Officer but will report to the appropriate IST chain-of-command if complexity dictates assignment of additional supervisors.

- Deployment
  - The IST Leader, with input from the IST Medical Officer and Safety Officer, makes the request for a PSP Response Package (personnel or Strike Team(s)) deployment to the ESF 9 Group Supervisor with justification.
  - The following factors may be used by the IST in making the decision to deploy PSP resources:

Possible Indicators for Behavioral Health Support

Note: This is not an exhaustive list, nor can all possibilities be considered.

Many of these are to be unique and dealt with on a case-by-case basis.

Time Frame	Indicator
During Mobilization	High probability for TF personnel to be involved with recovering deceased.
	Indications that children are a predominant portion of casualties (dead or injured).
	Threats identified that could pose direct harm to System personnel to include: ▪ Response to a terrorist incident ▪ Operations anticipated in very unstable structures ▪ Response to significant weather events ▪ Potential for threats that are hard to see and definitively quantify (e.g., certain chemical threats, biologic agents, radiologic incident response).
	Size and scale of incident as a consideration: ▪ Incident is anticipated to be very large requiring extended operations and anticipated System member fatigue Incident locations is in a small geographic location, but with high number of anticipated fatalities (e.g., structure collapse, bombing, etc.).
	The potential exists for System members to self-identify similarities with victims: ▪ Local response for a TF with significant casualties anticipated ▪ An incident with significant proportion of victims anticipated to be public safety personnel
During operations	**Any of the above identified during operations and**:
	Death or serious injury/illness of a System member ▪ Can include canine member ▪ Does not have to be a deployed member
	▪ Death or serious injury/illness of AHJ member with TF involvement ▪ Significant incident involving body recovery or multiple body recoveries

  - Once cleared to deploy by their SA/PA, PSPs deploy under regular IST deployment procedures making their way to the POA for the IST and in coordination with the IST POA/MOB.

- Field operations
  - PSP personnel have several roles:
    - Engage with System members and perform "active listening" to gather information on stressors
    - Evaluate incident parameters for stressors
    - Evaluate System members for stress
    - Refer, as appropriate, System members for further evaluation
    - Assist with facilitated discussions at the direction of leadership
      - PSP personnel may be asked to lead or support facilitated discussions
      - This may occur for IST personnel at the direction of IST Leader
      - This may occur for TF personnel at the direction of TF leadership
  - Focus of effort:
    - PSP personnel have been deployed to provider Peer Support to System members
    - There may be times in which they are asked to provide PEER Support to other public safety personnel at the direction of IST Leadership (anticipated to be rare)
    - They **should not** engage with citizens or the general public impacted by the incident.
  - PSP personnel take their supervision from the IST Medical Officer(s).
  - When initiating a Peer Support discussion with a System Member, PSP personnel should:
    - Clarify whether the discussion is with you as a PSP member
    - Review the limitations of confidentiality (see below)
    - Be mindful of the individual's need for privacy
    - Be aware of timing and circumstances
    - Most important – listen!
  - Confidentiality:
    - When initiating Peer Support with all individuals, PSP personnel should clearly delineate that all conversations are confidential with limitations:
      - The individual expressed the intent to hurt themselves
      - The individual expresses the intent to hurt others
  - Reporting:
    - PSP Response Package personnel have two types of reporting:
      - De-identified: Nonconfidential reporting to IST MOFRs and TF MTMs can provide general descriptors of numbers of individuals engaged, frequent stressors identified, and other broad information without naming individuals. This may be documented on the PSP ICS 214.
      - Confidential reporting: Names with associated conditions are only to be conveyed when a PSP has identified a member in crisis (see below

and as above under confidentiality) ONLY to the TF MTM and the IST MOFR.

- PSP personnel may be utilized in numerous ways:
  - Deployed to visit geographically dispersed Task Forces.
  - Centrally located at a large area of operations.
- When visiting a Task Force, PSP personnel should be pre-approved by the IST Operations Division Supervisor (DIVS), the IST Operations Branch Director (OPBD), or the IST Operations Section Chief (OSC) (dependent on size and complexity of the incident); **and** the TFL and also clearly announced to the TF members. PSP personnel should check in with TF leadership on arrival (a good opportunity to ask about leadership's perspective on stressors identified).
- In some cases, when working out of a central location, PSP personnel may require identification to assist System members in identifying them (e.g., vest or Velcro identifier on the work shirt/blouse).
- PSP personnel will always work in a minimum of two individuals (i.e., single PSP's are not deployed to visit TFs).
- PSP personnel should never:
  - Visit the immediate area of active US&R operations without ISTL, an operational supervisor (DIVS/OPBD/OSC), and TFL approval.
  - Interrupt personnel engaged in active US&R operations on a work site.
- PSP personnel stationed at a rehabilitation area of a work site may be appropriate with prior approval.
- PSP personnel should seek to follow up with individuals who have expressed concerns about incident stress.
- Referrals: When individuals are identified as potentially needing more formal behavioral health evaluation:
  - If there are concerns regarding immediate intervention, the individual in question should not be left alone (reinforcing PSP personnel operate in pairs).
  - Contact immediately the relevant MTM and/or IST MOFR.
  - Work with the relevant TFL and IST to establish referral method
  - In cases in which the individual is resistant to referral, and the MTM and IST MOFR agree with the referral, local law enforcement coordination may be required.
- PSP personnel are supported logistically by the IST.

- Demobilization
  - PSP personnel should re-engage with any individuals that have expressed concerns regarding stressors to "close the loop" and to ensure appropriate follow up is sought.
  - If any facilitated discussions are scheduled in the field with System personnel, remain available to lead or support as requested.

- Provide recommendations to demobilizing TFs (through the TF MTM and Safety Officer for monitoring that might need to occur upon return to home duty station.
- Provide any final reporting to the IST MOFR.
- Receive performance assessment from IST MOFR or IST DIVS
- Demobilization occurs per IST normal processes.
- Participate in AARs as requested.

- Post mission
  - Post Mission Medical (PMM) Guidance is completed by the IST SOFR and MOFR and the PSP generally does not modify or alter the document. The PSP may, however, be asked for input into the PMM.
  - Upon return to home unit, if continued follow-up occurs between the PSP and a System member, the PSP should make all attempts to refer the individual back to the individual's SA/PA for additional needs.

NOTE: The proposed position descriptions for the task force PSP and the IST PSP (Appendix D).

Recommendation 4 to the Advisory Group - IAFF Peer Support Contract (Pre-Incident)

Recommendation: The National US&R System should enter into a contract during non-critical times that will allow the US&R System to call upon them

- Consistent with the fifth tier of supporting Behavioral Health needs of System resources, it is recommended that the System contract with the IAFF to deploy and assist US&R resources.

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5	**IST requests external resources to deploy and assist US&R Resources – specifically the International Association of Firefighters (IAFF) Behavioral Health Support Team.**
Outlier/Special Circumstances	
6	A rare, specialized circumstance (such as Incident Within an Incident or IWI) in which PSPs or other behavioral health support from the Sponsoring/Participating Agency is requested and coordinated through the IST and Branch.

It is recommended that the US&R Branch enter into an arrangement with the IAFF Peer Support National Team to be called upon when all other measures have been exhausted, or the System has become overwhelmed.

- IAFF Peer Support Teams may be utilized in several ways:
  - Deployed to visit geographically dispersed Task Forces.
  - Centrally located at a large area of operations.
- When visiting a Task Force, IAFF personnel should be pre-approved by the IST Operations Division Supervisor (DIVS), the IST Operations Branch Director (OPBD), or the IST Operations Section Chief (OSC) (dependent on size and complexity of the incident); **and** the TFL and also clearly announced to

the TF members. IAFF personnel should check in with TF leadership on arrival (a good opportunity to ask about leadership's perspective on stressors identified).

- IAFF personnel will be clearly identified.
- IAFF personnel should never:
  - Visit the immediate area of active US&R operations without ISTL, an operational supervisor (DIVS/OPBD/OSC), and TFL approval.
  - Interrupt personnel engaged in active US&R operations on a work site.
- IAFF personnel stationed at a rehabilitation area of a work site may be appropriate with prior approval.
- IAFF personnel should seek to follow up with individuals who have expressed concerns about incident stress.
- Referrals: When individuals are identified as potentially needing more formal behavioral health evaluation:
  - If there are concerns regarding immediate intervention, the individual in question should not be left alone.
  - Contact immediately the relevant MTM and/or IST MOFR.
  - Work with the relevant TFL and IST to establish referral method
  - In cases in which the individual is resistant to referral, and the MTM and IST MOFR agree with the referral, local law enforcement coordination may be required.
- IAFF personnel will maintain their own support, unless it is specifically listed in the contract what logistics support they need from the IST.

Section 3- Recommendations for Suggested Implementation Into the US&R System

Recommendation 5 to the Advisory Group - Annual Screening (Pre-Incident)

Recommendation: Behavioral Health Screening should occur with regular Occupational Health physicals - a recommendation

- Sponsoring Agencies/Participating Agencies should include an element of behavioral health screening in regular health screening protocols for US&R Team members (e.g., with annual physicals). Some may already achieve this, and it is considered a holistic part of health screening.

- **Though this is a proposed recommendation and not a requirement, Sponsoring and Participating Agencies are strongly encouraged to provide this service.**

- In addition, Sponsoring and Participating Agencies should be aware that behavioral health screening requirements exist under NFPA 1582 and the OSHA proposed "Emergency Response Standard" – 29 CFR 1910.156 - if applicable. State and local statutes may exist as well for individual Task Forces.

- Behavioral health screening, co-administered with regular physical exams, usually takes the form of answering questions in a checklist format prior to the physical. This permits the examiner to further explore answers provided during the physical exam.

- If a Sponsoring Agency/Participating Agency is going to initiate behavioral health screening for its US&R personnel, it must **first** establish a capacity to handle individuals who screen positive during the process:
  - Individuals who screen positive should be referred in a timely fashion to a qualified behavioral health provider.
  - In some instances, this could be handled through an Employee Assistance Program (EAP)
  - In more severe cases, this could entail a referral to a therapist, psychologist, or psychiatrist.
  - The urgency of this referral should be expedited when the individual demonstrates potential risk to the safety of themselves or others.

- Some organizations, such as the First Responder Center of Excellence (FRCE), recommend regular behavioral health screening to include the following four issues:
  - Posttraumatic stress disorder (PTSD)
  - Major depressive disorder
  - Active suicidality
  - Substance use disorder

- There currently exists no common, validated tool designed specifically for US&R personnel and that covers all 4 areas.

- Many tools have been validated in different populations (some have been validated in fire fighters) or target selectively just one of the 4 topic areas.

- Examples include:
    - Primary Care PTSD Screen (PC PTSD-5)
    - PTSD Check List for DSM 5 (PCL 5)
    - Patient Health Questionnaire (PHQ-9)
    - Insomnia Severity Index (ISI)
    - Columbia Suicide Severity Rating Scale (CSSRS)
    - CAGE Substance Abuse Screening Tool
    - Drug Abuse Screening Test (DAST-10)
    - Alcohol Use Disorders Identification Test – Consumption (AUDIT C)
    - Others can be found at the Center for the Study of Traumatic Stress (CSTS) at the "Assessment Instruments for First Responders and Public Health Emergency Workers (cstsonline.org).

- Sponsoring Agencies establishing a new capability can consider borrowing a screening tool from a sister agency or developing their own drawing from some of the tools listed above:
    - As an example, a combination of PHQ 9, PTSD PCL 5, ISI, and Audit C combined could be a possible template (see attached).
    - Key concepts to keep in mind in the development of a new tool include sensitivity, specificity, efficiency, and acceptability for the application of the tool.

- As noted above, screening is ideally completed before the physical exam so that results can be reviewed by the occupational health provider before the exam and with the patient during the face-to-face interaction.

- Prior to administration, the individual should be told:
    - The purpose of the screening (i.e., not intended to diagnose but instead to identify symptoms that might indicate risk).
    - It is also considered part of holistic component of health screening.
    - Results from the screening will be held in a strictly confidential manner.
    - Results are not designed to remove a member from duty unless they indicate an immediate threat to the safety of self or others.
    - In all cases, internal policies and procedures for the Sponsoring or Participating Agency should be followed.

- As noted above, mechanisms for handling the results of screening should be established and robust.

Possible combination of tools that could be utilized during regular, on-going health screening utilizing pre-established tools

NOTE: An Example of recommended Behavioral Health Screenings conducted with annual physical exams are included with Appendix E

Recommendation 6 to the Advisory Group - Mobilization Screening (Deployment)

Recommendation: Behavioral Health Screening should not occur during mobilization activities - a recommendation

- After engagement with Subject Matter Experts, the Behavioral Health Ad Hoc feels that mobilization activities should not include formal behavioral health screening.

- US&R mobilization is a rapid process that requires the Task Force and their respective members to be ready for transport within hours.

- Though medical screening does occur during these activities, it is cursory and is intended to identify immediate health issues that can impact individual performance or that may impact the team itself (e.g., case of influenza).

- Formal behavioral health screening at the time of mobilization would be complicated to perform in a validated fashion, would require time to address any potential issues that arise, and requires significant attention to privacy.

- For these reasons, there are currently no validated recommendations to be made regarding mobilization behavioral health screening.

- Some Task Forces may wish to include an open-ended question during medical screening during mobilization to identify issues that may impact an individual's ability to perform on the mission. One example could be:
    - "This mission could be for an extended period. Is there anything going on in your personal, family or work life that may impact your ability to perform your assigned responsibilities on deployment?"
    - "Would you like to speak to anyone about it?"
    - "Is there anything that the TF can assist with?"
    - This type of open-ended question could reveal issues beyond behavioral health that the Task Force could potentially assist the individual with.

Recommendation 7 to the Advisory Group - Post-Incident Screening (Demobilization)

Recommendation: Behavioral Health Screening should be considered after an allotted time following deployments - a recommendation

- After engagement with Subject Matter Experts, the Behavioral Health Ad Hoc feels that behavioral health screening may have a role post-deployment.

- **Though this is a proposed recommendation and not a requirement, Sponsoring and Participating Agencies are strongly encouraged to provide this service.**

- Behavioral health screening after a deployment has the potential to identify any issues in an individual as a result of the deployment.

- As any deployment can be stressful and acute stress reactions are considered normal, it is recommended that this type of screening not be administered until at least one month after demobilization.

- As with regular on-going behavioral health screening:
    - A capability to handle individuals who screen positive must be established first.
    - It should be made clear to individuals that the screening is not diagnostic, but meant to identify potential issues from the deployment.
    - ~~e~~ All responses will be handled as confidential and the screening entity may coordinate with the MTM or Medical Director as needed.
    - Individuals who screen positive should be referred in a timely fashion to a qualified behavioral health provider.
    - In some instances, this could be handled through an Employee Assistance Program (EAP).
    - In more severe cases, this could entail a referral to a therapist, psychologist, or psychiatrist.
    - The urgency of this referral should be expedited when the individual demonstrates potential risk to the safety of themselves or others.

- Sponsoring Agencies establishing a new capability can consider borrowing a screening tool from a sister agency or developing their own drawing from some pre-established tools.
    - One approach can be to combine the following short screening tools:
        - Brief Inventory of Psychosocial Functioning (B-IPF)
        - Patient Health Questionnaire – 2 (PHQ-2)
        - Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)
        - Insomnia Severity Index – 3 (ISI-3)
        - Alcohol Use Disorders Identification Test (AUDIT-C)
    - These five short tools are useful, easy to administer, and combined could help a Task Force identify any behavioral health issues that require follow up. They total twenty questions overall and should not take long to complete for the member, nor for the MTM reviewing the scores

NOTE: These 5 tools are included with Appendix E

Recommendation 8 to the Advisory Group - Medical Team Manager / Medical Specialists Peer Support Training (Pre-Incident)

Recommendation: All Medical Team Managers / Medical Specialists in the System should be afforded the opportunity to undergo Peer Support Provider Training

- As a primary goal of this effort is to grow organic resources in the System, and Medial Team Managers (MTMs) could have Peer Support Providers (PSP) on their deployed Task Force, it is recommended that Sponsoring and Participating Agencies make PSP training available to their MTMs.

- **Though this is a proposed recommendation and not a requirement, Sponsoring and Participating Agencies are strongly encouraged to provide this service.**

- The US&R Interim Plan for addressing System behavioral health needs released in July 0f 2024 includes IST tracking of PSPs deployed in the field. Many teams have PSPs that could potentially deploy in a dual role with a primary focus on their rostered role.

- The intent is to grow organic resources within the teams with more PSP providers available. It is predicted that System members will respond more positively to PSPs from within the System, and from their own teams.

- Deployed MTMs already serve as a general medical provider in the field, including addressing behavioral health needs. However, most do not have formal PSP training.

- PSP training would provide MTMs with enhanced capabilities to interact with PSPs deployed with their Task Force.

- The courses that are available and meet System requirements include:
    - International Association of Firefighters – Peer Support training
    - University of Central Florida Restores: Recognize. Evaluate. Advocate. Coordinate. Track (REACT)
    - Boulder Crest: Struggle Well
    - International Critical Incident Stress Foundation (ICISF): Group Crisis Intervention and Assisting Individuals in Crisis
    - Texas Engineering Extension (TEEX): Support that Saves

Recommendation 9 to the Advisory Group - Canine Therapy (Steady State/Incident)

Recommendation: The System should approach the use of therapy canines during operations in a careful manner. It is recommended that more formal study and research be conducted as to this topic before embarking upon a System program.

- The Behavioral Health Ad Hoc investigated therapy canines and their potential application in the operational US&R environment. There was some disagreement among the group regarding formalizing a program, however, the following were agreed to:

    - The overall field of therapy canines is unregulated with little standardization and a wide range of providers offering services.
        - A System recommendation and training requirements would be required and folded into System doctrine, akin to Annex G - CSTCE; to include:
            - Development of a credentialing program (evaluation metrics, training, certification)
            - Support for ongoing maintenance of the canines.
            - A concept of operations for the use of therapy canines within the System.

    - Anecdotally, there was agreement that therapy canines are helpful.

    - Though used in an informal capacity, search canines should not be considered therapy canines. This may distract these animals from their designated mission and the temperament of some may not be conducive to the therapy task.

    - Outside programs offering assistance during operations should be carefully vetted by the IST or relevant TFs to ensure the animals in use:[1]
        - Are well controlled by their handlers
        - Have history of working with public safety personnel
        - Do not interfere or interact with search canines
    - There could be a future role for therapy canines deploying with System PSPs provided the above and either adequate funding is established, or the task force program management understands and accepts the extra needs surrounding a therapy canine if no additional funding is allocated.

[1] Given the lack of standardization, there is little formal guidance that can be given when evaluating outside offers of assistance. Leaders are appropriately cautioned.

Section 4- Conclusion

Throughout the various twice-monthly meetings, the in-person meeting and outreach from the ad hoc to members throughout the System, this document with recommendations, and attachments was created. Two additional recommendations have been included as **Appendix G and H**. These include a pocket guide for delivering bad news in the field (attachment e) and a recommended guidebook for System PSP members (Appendix F). Another Appendix provided is the overall timeline and work schedule from the BH AHG (Appendix I).

It is anticipated there will be ongoing behavioral health needs that require System discussion. It is recommended that a location within the Advisory Organization be identified and assigned to address continual and ongoing behavioral health needs. For example:

- Further examination of post-deployment behavioral health needs for the System.
- Behavioral health components of the incident within an incident (IWI) protocol.

On behalf of the BH AHG, we would like to thank the US&R Branch and the entire System for identifying the need, creating the support and assisting the BH AHG throughout this needed and important endeavor to provide better support to all System task force members.

Appendices

Appendix A- Interim Behavioral Health Plan

U.S. Department of Homeland Security
Washington, DC 20472

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US&R GENERAL MEMORANDUM – 2024-025

July 17, 2024

FOR: National Urban Search & Rescue Response System
Task Force Representatives

FROM: Mike Davis
Operations Section Chief (Acting)
Urban Search and Rescue Branch

SUBJECT: US&R General Memorandum 2024-025 – Behavioral Health Interim Plan

The purpose of this General Memorandum (GM) is to provide the National Urban Search and Rescue (US&R) Response System (the System) the interim plan that the System will utilize during this calendar year when identifying and addressing behavioral health needs during deployment.

The System has recently established a Behavioral Health Ad Hoc Group (AHG) which is anticipated to provide broader recommendations next year. To address needs in the upcoming year, the Branch has identified several actions that can be taken now to address behavioral health for our System members. These actions are meant to be tiered and escalate as incident parameters require. Primarily, they seek to:

- Utilize existing peer support resources embedded within task forces.
- Identify and utilize locally available and vetted behavioral health resources.
- Request additional outside resources as identified by the deployed IST, and the US&R Branch for any other significant unmet needs.

Implementation and socialization of the behavioral health support interim plan will assist our System members in ensuring their health and safety throughout this season while the Behavioral Health AHG continues to meet and recommend various solutions to the US&R Branch to assist our members.

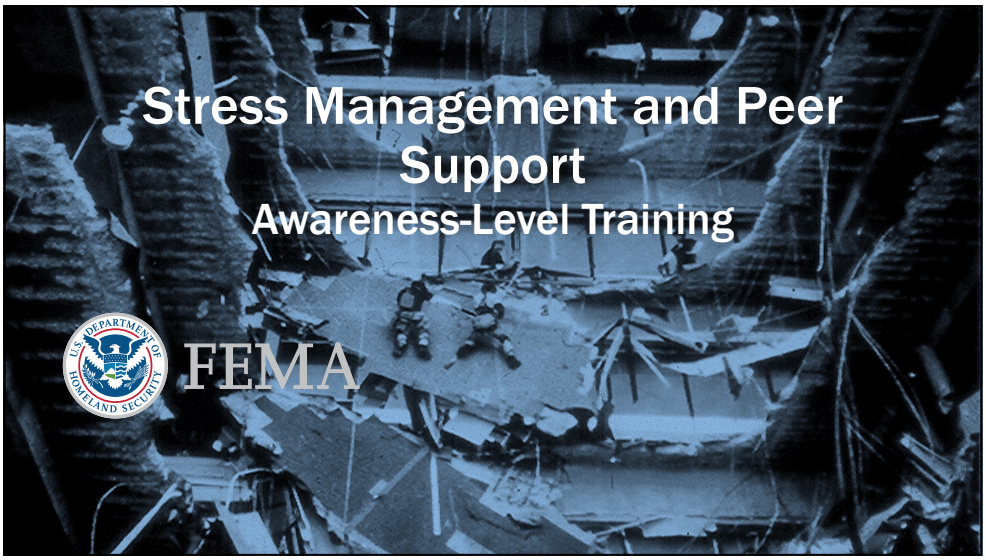
Questions regarding this GM may be directed to Michael Davis of the US&R Branch at: michaelb.davis@fema.dhs.gov.

Attachments (access via responsesystem.org in *Advisory Organization/Medical*):

National Urban Search and Rescue Response System Behavioral Health Support Interim Plan

cc:
US&R Strategic Group
US&R Advisory Group
US&R Branch Staff
FEMA Regional/Federal/International ESF #9 Representatives

www.fema.gov



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Awareness Level Stress Management
Basic Overview

- Directed Audience: All System members
- There are no pre-requisites for this course

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Video 1 – What it is Like Being on a US&R Mission

https://youtu.be/PvgvIF-4M2Y?list=PLTmq-mmUsWIGcaJ9gvA61DDYHYe7wymZX

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Objectives

- Understand the type of training being provided from this presentation (Awareness Level)
- Define stress and the different types of stress
- Recognize stress in self and others
- Understand coping mechanisms in self/others
- Determine strategies for developing stress resiliency
- Describe means for referrals of self/others to peer support
- Leadership support recommendations for US&R

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Video 2: Specific US&R Stressors

https://youtu.be/rssfBrFXtzE?list=PLTmq-mmUsWIGcaJ9gvA61DDYHYe7wymZX

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What is Stress?

- Stress is a naturally occurring reaction to life experiences
  - Something everyone experiences
  - Caused by anything from everyday responsibilities to serious life events
- Various reactions to stress
  - Everyone experiences stress differently and there are a broad range of reactions to stress
- Your body's response to stress
  - Release of hormones
  - Mental and Physical effects
- Difference between Acute or Chronic stress and Physiological/Psychological Stressors

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Eustress vs Distress

- Eustress or "positive stress"
  - Beneficial stress with positive outcomes producing excitement, pleasure, enjoyment, fulfillment
  - Examples: Starting new job, wedding, birth of a child, new life experiences, travel
- Distress or "negative stress"
  - Can cause feelings of anxiety, being overwhelmed, sadness, fear, worrying
  - Commonly experienced when a person is unable to alter or overcome stress/stressor
  - Can be immediate threat/trigger, or built up over time

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Acute Stress

- Acute stress is how you feel when facing an immediate threat or trigger
  - Acute stress is the most common type of stress
  - Experienced by most people a few times per day
  - These threats or triggers can come in physical, emotional, or psychological forms
  - Can be real or imagined
  - Examples: receiving deployment activation, travel during deployment, home planning while member is away
- Perceived stress equals real stress
  - Mild stressors can be simple, everyday occurrences
  - Acute stress can be more serious
  - The perception of the stress is what triggers the response and creates actual stress

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Video 3: Acute Stress

https://youtu.be/uIpk7Xk1cyQ?list=PLTmq-mmUsWIGcaJ9gvA61DDYHYe7wymZX

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Acute Stress

- Acute stress takes place immediately or up to four weeks after a traumatic event
- Generally lasts less than a month
- Acute stress must be treated as an emergent condition as a lack of treatment has a chance to lead to chronic stress or onset of PTSD

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Video 4: Chronic Stress

https://youtu.be/4O1rUuTCMWs?list=PLTmq-mmUsWIGcaJ9gvA61DDYHYe7wymZX

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Chronic Stress

- Chronic Stress (or repeated instances of acute stress) can cause larger problems:
  - Constantly having heightened anxiety can have mental and physical health effects
  - Autonomic nervous system cannot relax due to frequency or intensity of stress
- **Types of Chronic Stress:**
  - Emotional Stress
  - Environmental Stress
  - Relationship Stress
  - Work Stress
  - Financial Stress

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Physiological and Psychological Stressors

Some or all of these can be present in the US&R environment

- **Physiological:**
  - Extreme temperatures (hot or cold)
  - Strenuous physical activity, injury, illness, or pain
  - Acute/Chronic illness (getting ill on deployment or exacerbation of previous medical condition)
  - Exhaustion
  - A noisy or chaotic environment
- **Psychological:**
  - Various home-related stressors
  - Unintentional awakening or nightmares of previous personal loss or grief
  - Being overworked
  - Disagreement with coworkers or supervisor
  - Loss, grief or loneliness

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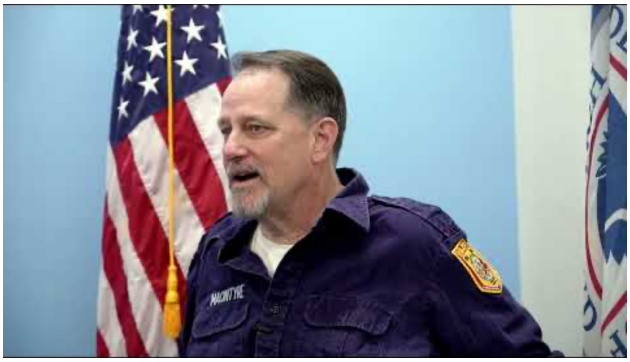
Video 5: Deployment Stress



https://youtu.be/729jclvMORE?list=PLTmq-mmUsWIGcaJ9gvA61DDYHYe7wymZX

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Stress in Yourself and Others in US&R

- Stress in the US&R environment is common before, during, and after response to an event
  - **Mobilization:** Family planning, ensuring equipment is ready, anticipation of being away from home for extended time
  - **Operations:** Performing physically, emotionally, mentally challenging missions or tasks while on deployment; **not** performing missions or tasks while deployed; lack of sleep; prolonged work cycles
  - **Demobilization:** Preparing to return home and the effects of what you missed, bringing the experiences of what you did home, possibility of unfinished work or unmet needs at the deployment location
  - **Rehabilitation/Return to readiness:** The task of ensuring the Task Force is mission ready in a quick, safe manner, and prepared to redeploy to the next mission.

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Video 6: Recognizing Stress in Self

https://youtu.be/wpxVKNAAjMw?list=PLTmq-mmUsWIGcaJ9gvA61DDYHYe7wymZX

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Recognizing Stress in Yourself and Others

- You may recognize these signs or symptoms at anytime during a deployment
- Your brain determines what is immediate danger and what is not
  - Your brain uses previous experiences (if any exist):
    - How did you feel during the event?
    - What was the immediate and ultimate outcome from the event?
    - How can you cope with the current stressor?
- Stress may manifest as a Fight, Flight, or Freeze response
  - Recognizing Fight, Flight, or Freeze responses is recognizing stress

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Fight, Flight, Freeze Responses

Reaction	Actual Response or Physiological Preparation
Fight	Taking immediate action to eliminate a threat/danger to yourself or others Aggressively dealing with a perceived threat or situation
Flight	Fleeing or leaving the perceived danger, threat, or situation "Survival" by removing yourself or others from the event
Freeze	Unable to exhibit Fight or Flight response You are unable to move, speak, or perform

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Various Indicators of Stress

PHYSICAL	THINKING	EMOTIONAL	BEHAVIORAL
• Digestive problems (stomachaches, vomiting) • Headaches, other aches and pains • Vision problems • Sweating • Chills • Muscle tremors, muscle twitching • Being easily startled • Fatigue • High blood pressure • Fast heart rate • Tooth grinding • Trouble breathing	• Disorientation and confusion • Trouble setting priorities and making decisions • Trouble concentrating and remembering things • Being more alert or less alert than usual • Difficulty solving problems • Nightmares • Greater or less awareness of surroundings • Intrusive thoughts	• Feeling heroic, euphoric, or invulnerable • Denial • Anxiety or fear • Depression • Guilt • Not caring about anything, or as much as usual about things • Sadness • Intense anger • Loss of control of expression of emotions	• Increase or decrease in activity level • Substance use (alcohol or drugs) • Angry outbursts, frequent arguments • Being unable to rest or relax • Worse performance at work and missing work • Frequent crying • Avoidance of activities and places that elicit memories • Choosing to be alone more of the time than usual • Eating more or less than usual

Source: International Critical Incident Stress Foundation, 2021

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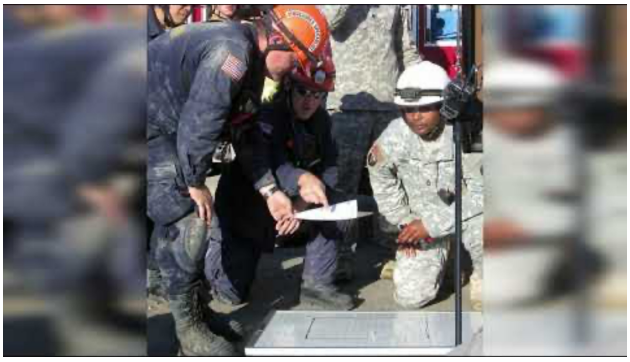
Video 7: Recognizing Stress in Others



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Recognizing Stress in Others

- Increased signs of stress can be affecting coworkers, and team members – the same factors that impact your stress levels could also be affecting your coworkers or team members
- You may notice:
  - Changes in behavior or mood
  - Changes in performance or ability to handle workload
  - Physical symptoms such as eating/sleeping habit changes
  - Increased complaints of physical ailments/symptoms
  - Decreased participation in missions/tasks, and or being distracted or not fully engaged
  - Withdrawal or isolation in team activities

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Understanding Coping

- Coping can be broken down into 4 categories:
  - **Problem-focused:** Directly addressing the problem causing the distress. i.e reducing and/or removing the stressor completely.
  - **Emotion-focused:** Attempting to reduce the negative emotions that come with the problem i.e. changing the perspective or appraisal of the stressor.
  - **Meaning-focused:** Using mental activity to manage stress or changing a person's perception of a situation (benefit finding) i.e. psychologist services, mindfulness meditation, deliberate heat / cold therapies, sleep routines.
  - **Social Coping:** Seeking support coping with stress through seeking help with groups, family, friends, Peer Support

Note: Religious Coping can be incorporated within these four categories

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Resiliency Practices

- A good baseline healthy lifestyle that is established in daily lives helps to provide a foundation to deal with stressors encountered when dealing with a deployment
- Benchmarks for building resilient pre-deployment habits can be associated with the acronym **DRESS**
  - **D – Diet:** Identifying and maintaining a proper diet
  - **R – Relaxation:** Finding moments or times that are appropriate, or scheduling times to relax
  - **E – Exercise:** Proper amounts of exercise several times a week for a minimum of 30 minutes
  - **S – Sleep:** Proper sleep is one of the most important elements to cope with acute stress
  - **S – Socialization:** Important connection with others is an important part of the coping process
- DRESS can be used as a checklist for personal needs to be met during deployment

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Video 8: Recognizing Coping Mechanisms

https://youtu.be/sSF6AM-xhMg?list=PLTmq-mmUsWIGcaJ9gvA61DDYHYe7wymZX

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Recognizing Coping Mechanisms

- Coping mechanisms are important to recognize in not only yourself, but others as well
- Paying attention to others and their actions, along with your own, can help determine if additional resources are needed
- It is paramount to develop a battery of healthy coping mechanisms to combat acute and chronic stress
- Healthy coping mechanisms will enable yourself, your team members, coworkers, and family the ability to handle stress

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Unhealthy Coping Mechanisms

All coping mechanisms can become unhealthy when used in excess

- Be aware of excessive use of:
  - Alcohol
  - Pornography
  - Unhealthy eating habits
  - Caffeine
  - Casual and copious sexual encounters (hook-ups)
  - Isolation
  - Tobacco products
  - Related media and social media

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Healthy Coping Mechanisms

- Examples of Healthy Coping Mechanisms:
  - Getting enough sleep and rest – this can be a challenge on shift work or deployment
  - Meaningful connection with other humans
  - Taking breaks from social media, news, electronics – unplug for a while
  - Eating healthy – make the best food options possible while on deployment and in everyday life
  - Staying active and moving – attempt to get as much exercise and movement as possible
  - Limiting alcohol intake, avoiding illegal drugs, not misusing prescription drugs
  - Talking with someone about your stress -- Peer Support is here for everyone
  - Journaling
  - Mindfulness & meditation

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Stress Resiliency

- Recognize Stress – When stress occurs, use healthy habits and coping skills to deal with acute and chronic stress
- Maintaining positive relationships, positive attitude, and positive mindset are also tools to build resiliency
- Keeping things in perspective – Sometimes we can't save everyone and no matter what there are outcomes that we cannot control
- Focusing on self-discovery opportunities
  - Try to find ways to use your experience at an event as a way to grow as a person
  - Learn how to use your experiences at an event as a tool for becoming better for your next mission

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Stress Resiliency

- Develop realistic goals and move toward achieving them:
  - Small goals that combine to accomplish a larger one
  - Set regular goals that might not be easy, but are achievable
  - Continue to progress towards a larger goal
- Acceptance of change:
  - The US&R world is a fluid one that is full of constant change
  - We are continuously making progress towards doing things better
- Make decisive decisions, use decisive actions – Try to avoid detaching from problems or stress; take the coping mechanisms that work best for you to make decisive decisions and actions

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Stress Resiliency

- **Take care of yourself:**
  - Pay close attention to your self-care, engage in activities that enhance your ability to deal with stress and help you relax
  - Keep your mind, body, and emotions in a ready state to deal with acute and chronic stress
- **Take care of each other:**
  - Pay close attention to your crews and check-in regularly with their physical and emotional well-being
  - Reach out to trusted leaders or peer support if you feel someone else needs help

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Leadership in Stressful Environments

- What leaders say and do during times of crisis has an impact not only on the well-being of personnel, but the trajectory of recovery for a community
- Be present with Task Force members during operations:
  - Allows leadership a greater understanding of the members' experience
  - Allows leaders to understand what is happening to members in a way that is very hard to do from a distance
  - Provides opportunity to role model behaviors that protect health and foster resilience.

Source: Dr. Joshua Morganstein, M.D., DFAPA & Dr. Curt West, M.D., DFAPA "Disaster and Preventive Psychiatry"

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Leadership Behaviors to Foster Resilience and Sustainment

- **Communicate Regularly:**
  - Share what you know and what is unknown
  - Let crews know what protective actions are being taken to care for them
  - Ask questions and get answers
- **Provide Resources:**
  - Obtain needed equipment and supplies
  - Train people on how to use them
  - Advocate for things that are needed to optimize care and recovery (Work/Rest Cycle)

Source: Dr. Joshua Morganstein, M.D., DFAPA & Dr. Curt West, M.D., DFAPA "Disaster and Preventive Psychiatry"

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Leadership Behaviors to Foster Resilience and Sustainment

- **Normalize Reactions:**
  - Educate crews on common and expected responses
  - Talk openly about reactions you and others are having
  - Respect differences in how people express emotions (i.e., anger, sadness, denial, withdrawal can all be adaptive.)
- **Role Model:**
  - Demonstrate self-care and coping strategies to encourage these in others, which
  - "Lead by Example" to improve performance

Source: Dr. Joshua Morganstein, M.D., DFAPA & Dr. Curt West, M.D., DFAPA "Disaster and Preventive Psychiatry"

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Video 9: Leadership in the US&R System

https://youtu.be/qfI2ANW07rE?list=PLTmq-mmUsWIGcaJ9gvA61DDYHYe7wymZX

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Leadership Behaviors to Foster Resilience and Sustainment

- **Promote Peer Support:**
  - Encourage informal and formal peer support to promote cohesion, efficacy, safety, and morale
  - Ensure policies and procedures facilitate peer support actions.
- **Address Grief:**
  - Anticipate that grief occurs over many losses that occur
  - Communicate regularly with people with the goal of recognizing losses and helping to make meaning of the event
  - Honor losses through community-conceived and implemented activities

Source: Dr. Joshua Morganstein, M.D., DFAPA & Dr. Curt West, M.D., DFAPA "Disaster and Preventive Psychiatry"

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Leadership Behaviors to Foster Resilience and Sustainment

- **Think Forward:**
  - Be realistic but think about where things need to go
  - Communicate in hopeful manner to remind people things will end, most people will be okay and some may ultimately emerge feeling stronger

Source: Dr. Joshua Morganstein, M.D., DFAPA & Dr. Curt West, M.D., DFAPA "Disaster and Preventive Psychiatry"

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Support During Phases of Deployments

- **Mobilization:**
  - Educating members on the type of work to be done
  - Hazards they can expect to encounter
  - Policies, procedures, and protective equipment to keep them safe and healthy
  - Informing how their families and home life will be supported (Deployment Support Team)
- **Operations:**
  - Focus of support may shift to monitoring and providing support as needed
  - Peer check-in's, AAR's, and buddy checks

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Support During Phases of Deployments

- **Demobilization:**
  - Support will shift to preparing workers for life as usual, anticipation of being back home.
  - Educating members of the excitement of returning home and reality of home stressors upon return
  - Screening to identify those with persisting or severe distress and referring them to appropriate care.
  - Additional referrals or resources might be necessary.

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Video 10: Stress Referrals For Self/Others

https://youtu.be/T_xJzWjtg-g?list=PLTmq-mmUsWIGcaJ9gvA61DDYHYe7wymZX

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Questions?

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Behavioral Health Ad Hoc Group - Composition

Name	Affiliation	Name	Affiliation
Christy Bormann	TX-TF1(Central)	Jared Strote	WA-TF1 (West)
Mike Boyle	CA-TF5 (West)	Qing Wang	IN-TF1 (Central)
Jacob Windell	CA-TF2 (West)	Bradley Wilt	MD-TF1 (East)
Marc Grossman	MA-TF1 (East)		
Co-Chair: Bret Fossum	UT-TF1 (Central)	Co-Chair: Anthony Macintyre	FEMA

A special thanks to Local 1664 – Montgomery County Career Firefighters Association for videography

FEMA

Federal Emergency Management Agency 41

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21

749

750

Appendix C- Example of Behavioral Health Screening conducted with annual physical exams

PHQ 9

Over the past two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1) Little interest or pleasure in doing things	0	1	2	3
2) Feeling down, depressed or hopeless	0	1	2	3
3) Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4) Feeling tired or having little energy	0	1	2	3
5) Poor appetite or overeating	0	1	2	3
6) Feeling bad about yourself….or that you are a failure or have let yourself or your family down	0	1	2	3
7) Trouble concentrating on things, such as reading a newspaper or watching television	0	1	2	3
8) Moving or speaking so slowly that other people could have noticed. Or the opposite….being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9) Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

10: If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

If there are a minimum of four checks in shaded area, consider depressive disorder.

For total score, consider:

1-4: minimal depression

5-9: mild depression

10-14: moderate depression

15-19: moderately severe depression

20-27: severe depression

PTSD PC 5

Sometimes, things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- A serious fire
- A physical or sexual assault or abuse
- An earthquake or flood
- A war
- Seeing someone be killed or seriously injured
- Having a loved one die through homicide or suicide

Have you ever experienced this kind of event?

YES___ NO____

If no, stop survey. If yes, continue to the next 5 questions.

In the past month, have you:

1) Had nightmares about the event(s) or thought about the event(s) when you did not want to? Y/N
2) Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
   Y/N
3) Been constantly on guard, or easily startled?
   Y/N
4) Felt numb or detached from people, activities, or your surroundings?
   Y/N
5) Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?
   Y/N

Of the above questions, if respondent replies YES to 4 of the questions, consider additional screening or referral. Per the VA, consider lower threshold for females to 3 questions answered affirmatively to reduce false negatives.

Insomnia Severity Index

1) Please rate the current (i.e., last 2 weeks) SEVERITY of your insomnia problem(s):

	None	Mild	Moderate	Severe	Very
Difficulty falling asleep	0	1	2	3	4
Difficulty staying asleep	0	1	2	3	4
Problem waking up too early	0	1	2	3	4

2) How SATISFIED/DISSATISFIED are you with your current sleep pattern?

Very satisfied				Very dissatisfied
0	1	2	3	4

3) To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)

Not at all interfering	A little	Somewhat	Much	Very much interfering
0	1	2	3	4

4) How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?

Not at all noticeable	Barely	Somewhat	Much	Very much noticeable
0	1	2	3	4

5) How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all	A little	Somewhat	Much	Very much
0	1	2	3	4

Scoring

0-7: No clinically significant insomnia

8-14: Subthreshold insomnia

15-21: Clinical insomnia (moderate)

22-28: Clinical insomnia (severe)

NOTE: The phrasing of this questionnaire appears to presume the respondent has a sleep problem and may not be appropriate as written.

AUDIT C

Question	Answer	Score
How often did you have a drink containing alcohol in the past year?	Never	0
	Monthly or less	1
	2-4 times per month	2
	2-3 times per week	3
	4 or more times per week	4
On the days in the past year when you drank alcohol, how many drinks did you typically drink?	0, 1, or 2	0
	3 or 4	1
	5 or 6	2
	7-9	3
	10 or more	4
How often did you have 6 or more (for men) or 4 or more (for women and everyone 65 and older) drinks on an occasion in the past year?	Never	0
	Less than monthly	1
	Monthly	2
	Weekly	3
	Daily or almost daily	4

The VA considers the screen as positive if the score is 5 points or greater.

Appendix D- Proposed Position Description for Task Force PSP

Peer Support Provider

Task Force Position Description

A. Functional Description

The task force Peer Support Provider (PSP) is responsible for the monitoring and supporting the behavioral health requirements of task force members while deployed. The US&R environment is complex, and individuals may be stressed by the deployment itself, team dynamics or events at home. This position is unique for several reasons:

- PSPs can deploy in their regular role on the Task Force, but because of their secondary skill set, can provide first line, behavioral health support to deployed members on their task force. There may be situations where PSPs can deploy to augment their standard task force configuration and will be serving primarily in a peer support role.
- When assigned to a non-PSP position, the individual follows their regular assigned chain of command, unless they are specifically addressing a peer support issue. In this instance, they will work with the deployed Medical Team Manager (MTM) to address outstanding issues.
- When assigned to work in the primary role of a PSP, they will work for and report directly to the MTM or Medical Specialist as assigned.
- There is no national mandate to deploy task force members with PSP training and experience, but this skill set is tracked on team fact sheets for the IST to monitor capabilities in the field.

B. Description of Duties

The Peer Support Provider is responsible for the following:

1. Identification, tracking and support to task force personnel's mental health and behavioral wellness.
2. Facilitating or leading behavioral health debriefings.
3. Escalating identified issues beyond their knowledge, skills and abilities to the MTM.
4. Maintaining appropriate confidentiality regarding information discussed with deployed task force members based on home agency policies and procedures.
5. Making recommendations as to when peer support augmentation may be required for the team.

C. Position Requirements and Criteria

Individuals who meet the following requirements and criteria will be eligible to become Task Force Peer Support Providers in the National US&R Response System. The intent of these requirements is to select trained and qualified individuals that are capable of assisting task

force members in a complex and oft-times austere search and rescue environment.

Individuals listed on the task force Team Fact Sheet or serve in a TF augmented role as PSPs must have their Sponsoring Agencies/Participating Agencies endorsement to serve in that role.

D. Required Training

The Peer Support Provider shall adhere to the following:

1. Meet all Administrative and General training requirements for System members
2. Have the recommendation of their task force to function in a peer support capability (on peer support at their home agency or qualified and trained as a peer supporter)
3. A minimum of one of the following trainings:
    - International Association of Firefighters – Peer Support training
    - University of Central Florida Restores: Recognize. Evaluate. Advocate. Coordinate. Track (REACT)
    - Boulder Crest: Struggle Well
    - International Critical Incident Stress Foundation (ICISF): Group Crisis Intervention and Assisting Individuals in Crisis
    - Texas Engineering Extension (TEEX): Support that Saves

E. Recommended Training

The Peer Support Member is recommended to complete the IAFF Disaster Response Peer Support course, and one of the following:

- Assessing and Managing Suicide Risk (AMSR) from Zero Suicide Institute
- IAFF Safety Planning Intervention for Suicide Prevention
- Applied Suicide Intervention Skills Training (ASIST) from Living Works
- Counseling on Access to Lethal Means from Suicide Prevention Resource Center

IST Peer Support Provider

Position Description

A. Functional Description

1. The Incident Support Team (IST) Peer Support Member Provider (PSP) is responsible for monitoring and supporting the behavioral health requirements of US&R Task Force Personnel assigned to the area of operations.
2. The IST PSPs report(s) to the IST Medical Officer (MOFR) or IST Division Group Supervisor (DIVS) and is responsible for assisting the IST Medical Officer in providing behavioral health support.
3. IST PSPs are considered auxiliary IST members and are only deployed at the request of the IST MOFR and IST Leader (ISTL).

B. Description of Duties

The IST Peer Support Provider is responsible for the following:

1. Identification, tracking and support to task force personnel mental health and behavioral wellness
2. Facilitating or leading behavioral health debriefings
3. Escalating identified issues beyond their knowledge, skills and abilities to the IST MOFR
4. Maintaining appropriate confidentiality regarding information discussed with deployed task force members* (FEMA OCC input required on limits of confidentiality)
5. Making recommendations as to when peer support augmentation may be required for the deployed System members.
6. May be required to travel in between teams stationed in various locations within the AOR.

C. Position Requirements and Criteria

Individuals who meet the following requirements and criteria will be eligible to become IST Peer Support Providers in the National US&R Response System. The intent of these requirements is to select trained and qualified individuals that can assist task force members in a complex and oft-times austere search and rescue environment.

D. Required Training

The IST Peer Support Provider shall adhere to the following:

1. Meet all Administrative and General training requirements for System members
2. Have the recommendation of their Sponsoring Agency/Participating Agency to function in a peer support capability on the IST (on peer support at their home agency or qualified

and trained as a peer supporter)

3. IST New Member Orientation

4. A minimum of one of the following trainings:
    - International Association of Firefighters – Peer Support training
    - University of Central Florida Restores: Recognize. Evaluate. Advocate. Coordinate. Track (REACT)
    - Boulder Crest: Struggle Well
    - International Critical Incident Stress Foundation (ICISF): Group Crisis Intervention and Assisting Individuals in Crisis
    - Texas Engineering Extension (TEEX): Support that Saves

E. Required Experience

The IST Peer Support Member shall have the following minimum experience:

1. Five years of demonstrated experience in the FEMA US&R System, and
2. A current member of their agency's Peer Support Program, or validation from the Sponsoring Agency/Participating Agency Chief if no Peer Support program exists
3. Three deployments (to include actual task force deployments and deployment exercises) in any position, or
4. Three deployments on a Type III or greater Incident Management Team (IMT) in any position

F. Recommended Training

The Peer Support Member is recommended to complete the IAFF Disaster Response Peer Support course, and one of the following:

- Assessing and Managing Suicide Risk (AMSR) from Zero Suicide Institute
- IAFF Safety Planning Intervention for Suicide Prevention
- Applied Suicide Intervention Skills Training (ASIST) from Living Works
- Counseling on Access to Lethal Means from Suicide Prevention Resource Center

Appendix E- Screening Tools Recommended to be Filled by Task Force Members One Month Post-Deployment

Brief Inventory of Psychosocial Functioning (B-IPF)

Overall, in the past 30 days:	Not at all / N/A	Somewhat					Very much
1. I had trouble in my romantic relationship with my spouse or partner.	0	1	2	3	4	5	6
2. I had trouble in my relationship with my children.	0	1	2	3	4	5	6
3. I had trouble with my family relationships.	0	1	2	3	4	5	6
4. I had trouble with my friendships and socializing.	0	1	2	3	4	5	6
5. I had trouble at work.	0	1	2	3	4	5	6
6. I had trouble with my training and education.	0	1	2	3	4	5	6
7. I had trouble with day-to-day activities, such as doing household chores, running errands and managing my medical care.	0	1	2	3	4	5	6

Scoring:

Respondents only answer questions on the B-IPF pertaining to domains that have been relevant in the past 30 days. The B-IPF total score is calculated by summing the scale items completed by the respondent, dividing by the maximum possible score based upon the number of applicable items and multiplying by 100. B-IPF total scores represent an index of overall functional impairment, with higher scores indicating greater functional impairment.

Patient Health Questionnaire – 2 (PHQ-2)

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	+1	+2	+3
2. Feeling down, depressed or hopeless	0	+1	+2	+3

Scoring Interpretation:

A PHQ-2 score ranges from 0-6. The authors identified a score of 3 as the optimal cutpoint when using the PHQ-2 to screen for depression.

If the score is 3 or greater, major depressive disorder is likely.

Patients who screen positive should be further evaluated with the PHQ-9, other diagnostic instruments, or direct interview to determine whether they meet criteria for a depressive disorder.

Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)

In the past month, have you:		
Had nightmares about the event(s) or thought about the event(s) when you did not want to?	Yes	No

Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	Yes	No
Been constantly on guard, watchful, or easily startled?	Yes	No
Felt numb or detached from people, activities, or your surroundings?	Yes	No
Felt guilty or unable to stop blaming yourself or others for the events(s) or any problems the event(s) may have caused?	Yes	No

Scoring Interpretation: Current research suggests that the results of the PC-PTSD-5 should be considered "positive" if a patient answers "yes" to any three items.

Insomnia Severity Index – 3 (ISI-3)

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = _____ your total score

Total score categories:
0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

Alcohol Use Disorders Identification Test (AUDIT-C)

AUDIT-C	
Q1: How often did you have a drink containing alcohol in the past year?	
Answer	Points
Never	0
Monthly or less	1
Two to four times a month	2
Two to three times a week	3
Four or more times a week	4
Q2: How many drinks did you have on a typical day when you were drinking in the past year?	
Answer	Points
None, I do not drink	0
1 or 2	0
3 or 4	1
5 or 6	2
7 to 9	3
10 or more	4
Q3: How often did you have six or more drinks on one occasion in the past year?	
Answer	Points
Never	0
Less than monthly	1
Monthly	2
Weekly	3
Daily or almost daily	4

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety.

Appendix F- Pocket Guide for Delivering Bad News in the Field

Delivering Bad News During Deployment

Informing a community member of death or injury to a loved one is an infrequent but challenging part of an urban search and rescue mission. There is no one right way to have such a conversation. The following suggestions for consideration are intended to help prepare you and provide a framework for when such a conversation becomes necessary.

1. **Consider where the conversation should be held.** When possible, moving from an active search site to a safe, quiet, and private place is best.

2. **Be conscious of the cultural norms where you are working.** These may affect how death is discussed.

3. **If possible, remove helmets and sunglasses to allow for direct eye contact.**

4. **Introduce yourself and explain your role.**

5. **Consider starting with a direct statement.** "I have some bad news to tell you" or a similar opening remark can prepare the family for the information that is to come.

6. **Speak slowly in simple and direct language.** Processing bad news is difficult but describing the death or injury clearly and directly will ensure there is understanding.

7. **Periods of silence are to be expected.** These are often necessary for processing what is being said.

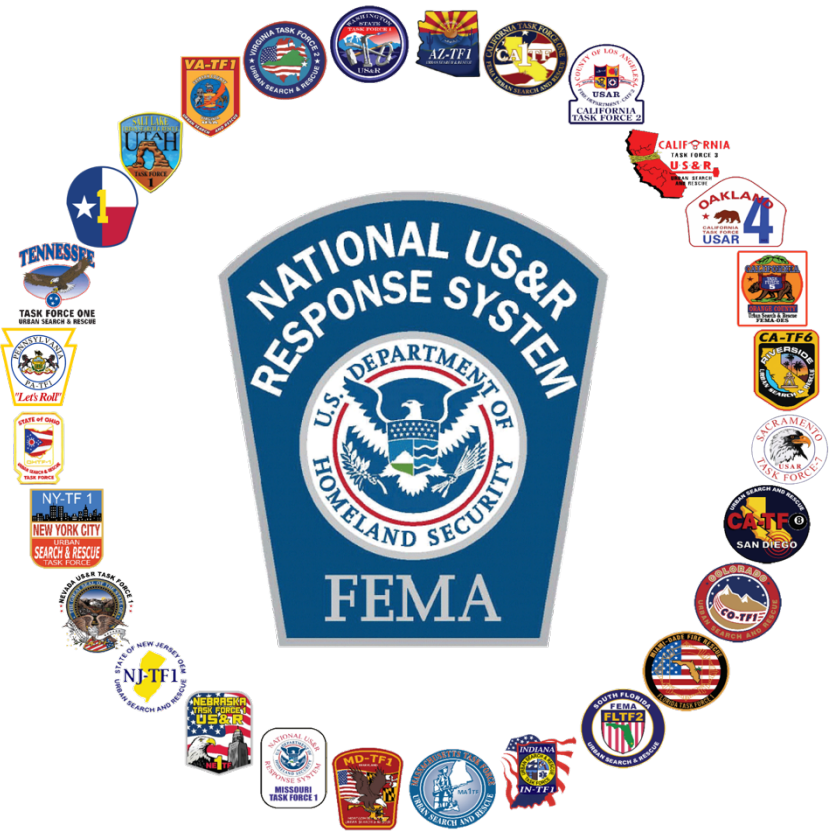
8. **Show sympathy and kindness**. Acknowledging and respecting the difficulty of the situation, expressing understanding, and/or remaining available to listen may help both you and the listener process the experience.

9. **Be prepared for a broad range of responses.** These may include turning away, prolonged silence, a desire to discuss what has happened, a description of the person who has been lost, as well as anger and aggression.

10. **Be aware of how delivering bad news impacts you and give yourself space to process the experience once it is over.** This may require time away from search operations immediately and/or space at various points later on during the deployment. Use of formal and informal peer support and conversations can be helpful to manage the challenges of delivering bad news.

Appendix G- FEMA US&R Peer Support Manual

FEMA Urban Search & Rescue Peer Support Manual



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Welcome

Welcome to peer support! This manual will guide you through some of the basic situations you may encounter. One of our goals in peer support is to reduce the risk of PTSD and suicide among our fellow System members. Your role as a peer supporter is to help make this happen by being there for your colleagues through hard times. This guide contains resources regarding the ethics of peer support, how to deal with suicidality, legal requirements, considerations, and recommendations of things to avoid.

Team, Definitions, Roles, and Tips

Peer Support Team Mission

The Peer Support Providers (PSP) functions as a support and debriefing resource, primarily for US&R System members. The PSP provides support to personnel experiencing personal and work-related stress and offers support during and following critical or traumatic incidents due to job responsibilities.

Peer Support Providers:

- Provide peer support and facilitate peer support team debriefings within both the scope of their training and consistent with established legal, departmental, operational, and ethical guidelines.
- Attend scheduled peer support team meetings and in-service training as required by the System.
- Develop and maintain enhanced knowledge and skills in recognizing: 1) stress reactions to critical incidents, and 2) the chronic stressors of search & rescue and non-work environments.

Resolve issues or conflicts that may arise with supervisors by working for cooperation, understanding, and education. If resolution is not readily achieved, coordinate with the relevant task force (TF) Medical Team Manager (MTM) or the Incident Support Team (IST) Medical Officer (MOFR) immediately for assistance.

- Make appropriate referrals when issues exceed the parameters of peer support, generally through the MTM or MOFR.

- Understand the ability and constraints in providing peer support services to other task forces (upon request and as approved through ISTL, MOFR, TF TFL and TF MTM).
- Remain mindful of the trust placed in them by those who seek peer support.

Peer Support Interactions:

- Are founded on similar experiences, backgrounds, or histories.
- Are characterized by elements of functional relationships.
- Encourage exploration, empowerment, and positive change.
- Avoid the creation of dependency.
- Are guided by ethical and conceptual parameters.
- It is different from "friends talking".
- Can be a one-time contact or ongoing.

May involve an evaluative component.

Definitions

Confidentiality: A professional promise not to share information (with certain limitations).

Counseling: A professional therapeutic relationship wherein a specially trained and licensed clinician helps another person understand and solve past or current issues and difficulties.

Peer support: A non-professional interpersonal interaction based on a common experience or history. Peer support differs from counseling and psychotherapy, where a common experience or history is not necessary. There are two levels of peer support: Level I involves everyday interactions of friends, co-workers, and others. Level II involves trained individuals who endorse specified ethical standards, function under clinical supervision, and are members of a peer support team.

Privacy: A protection of an individual's personal information.

Privilege: Legal principle that one cannot be forced to share information.

Psychotherapy: A professional form of counseling used as a treatment for mental disorders, involving psychological techniques and assessments to relieve symptoms or alter personality.

The Peer Support Provider Role

Peer support providers are responsible for:

- Clarifying whether an interaction is peer support and, if confirmed, specifying both the PSP member's role and the parameters of peer support interactions.
- Advising and explaining the limits of confidentiality in peer support interactions before engaging in peer support.

One should always refer to home agency peers support program and policies. This document is primarily meant to support those that are deployed as a PSP in the System.

Peer support providers function in multiple roles. The confidentiality protections afforded to peer support providers do not apply when they are functioning in a role other than peer support. Therefore, it is important for peer support team members to remain aware of when they are and are not functioning in their peer support role. When interacting with others, unless clearly functioning in a peer support role, PSP should ask themselves:

- Is this a peer support interaction or just a friendly conversation?
- Is there a possibility that the person believes they are talking to me in my peer support role even though I'm uncertain?

If uncertain, ask, "Are you talking to me as a member of the peer support team? Is this peer support?" If "yes," specify the limits of PSP member confidentiality and continue the conversation as peer support.

Peer support: Think - "What is this person trying to tell me?" "How might I help?"

At times, peer support interactions can be stressful. Try to relax and focus on the interaction. Keep in mind that a functional peer relationship is inherently supportive. You do not need to force anything to be effective.

Tips

Helpful Phrases

The following sentences and phrases may be helpful during peer support interactions. Consider circumstances, immediate context, and

the emotional state of others when engaging in peer support. A statement of support or exploratory inquiry that is appropriate in one circumstance may not be appropriate in others.

Supportive:

It's good to see you...
I'm glad... (you're ok, here, uninjured, to see you, etc)
You have been through a lot...
That was one helluva day...

Exploratory:

Tell me more.
Would you like to talk about what happened?
Did something stressful happen recently?
Bring me up to date on...
Let's take some time to go over this...
Can you help me to understand...
How would X help you with Y...
What would happen if you did (did not) do...
What are the likely consequences of...
Do you see any alternatives (options, implications, etc) to...
What I think you're saying is...is this accurate?
You feel...because...?
If I'm following you, you feel... because...
Have you thought about how this could be different?
I'm not clear on...can you help me to better understand?
What are your thoughts/feelings on this (making it better, coping, etc)?
What are your greatest fears about...
Can you talk more about your thoughts/feelings about...
What will the next few days be like for you?
What are your plans for the next few days?
It's been __ days since __. How are you doing? What has been happening?
What is happening now for you?
How will you deal with this experience (anger, pain, incident, loss, etc)?

Combination of Supportive and Exploratory:
That's a lot to deal with. This sounds like a difficult time for you. Let's see if we can come up with a plan to manage things over the next few days...do you have any ideas?

Generally, it is beneficial to avoid asking "How does that make you feel?" and saying things like "What I hear you saying is..." when engaged in peer support exploration. These statements have too much potential to be regarded as cliché, mechanical, and sterile. They often diminish the perceived authenticity and genuineness of the peer support interaction. This is because it is not the manner in which most people speak to their peers in everyday conversations.

Assessment:
How would you describe your feelings (thoughts) right now?
Have you had any thoughts, feelings, or experiences that are strange or unusual for you?
Have you had thoughts of suicide or hurting yourself?
Are you thinking about harming someone else?

These suggestions for peer support do not represent an exhaustive list. In this regard, you are limited only by your imagination, training, perceptions, and appropriate boundaries.

In peer support communication there is no substitute for common sense.

General Tips:

- Find a comfortable physical setting when possible.
- Keep in mind that privacy may be very important for the person.
- Clarify your PSP role and specify PSP limits of confidentiality.
- Be mindful of timing and circumstances.
- Develop a working alliance.
- Engage appropriate humor when suitable. Don't overdo it!
- Make it safe for communication.
- Proceed slowly – it is not helpful to be perceived as "rushed."
- Listen closely – speak briefly.

- Listen for metaphors that can be used in exploration - use similar metaphors when appropriate.
- Do not assume that you know the person's feelings, thoughts, and behaviors.
- Avoid interruptions and distractions (from you and the environment).
- Process information in a supportive manner – engage attentive body language, practice active listening, maintain a non-judgmental attitude, use reflective statements, paraphrase.
- Notice resistance – communicate to process alternatives.
- Emphasize strengths – encourage empowerment.
- When in doubt, focus on emotions and feelings.
- When you don't know what to say, say nothing or "Tell me more."
- Pay attention to nonverbal behaviors (mind yours and notice theirs).
- Agreement does not equal empathy – you do not need to agree with the views of a person to be empathetic.
- Do not reinforce dysfunctional thoughts and behaviors.
- Gently confront dysfunctional thoughts and behaviors.
- Remember, if you confront too much too soon, the person will likely disengage from you and peer support.
- Do not assume change is easy – identify and discuss obstacles to change.
- Summarize periodically and at the end of the support meeting.
- Stay within the boundaries of your peer support training.
- Bring your interactions under clinical supervision.
- Refer to available professional resources when appropriate.

Questions and Answers

Do I need to check with my operational supervisor or task force leader before I engage in a peer support interaction?

Sometimes. You should have permission from the TF TFL or MTM before working closely within a task force. When deployed as a part of the PSP Response Package, you are working for the IST, you should have guidance from the IST MOFR prior to deploying to other areas or

approaching task forces. PSPs that are deployed as part of the task force should follow the direction of their Medical Team Manager. As a trained peer support provider, you may initiate or respond to a request for peer support. Independent peer support provider interactions, which comply with lIST operational guidelines, are appropriate and encouraged.

How do I respond to a person who asks if peer support interactions are confidential?

When asked if peer support interactions are confidential, you should fully explain the limits of peer support provider confidentiality. Remember to include that PSP information may be provided to the TF MTM or IST MOFR. An unacceptable reply to this question would be a cursory remark such as "yeah, they're confidential, there's a law."

What happens when a person to whom I have been providing peer support waives his or her privilege of confidentiality?

When a person to whom you have been providing peer support waives confidentiality, the content of his or her peer support communications becomes available for disclosure. This means that you may communicate information received from the person in peer support interactions, but only to those identified in the waiver. A person normally waives confidentiality for some reason, usually so that you can communicate with specific family members, supervisors, lawyers, and so forth. Regardless of the reason, under the waiver, the information communicated to you by the person becomes available. PST members must remain aware that the prohibition against revealing peer support information without consent (within confidentiality limits) restricts only the peer support provider. The person with whom you are involved in a peer support interaction is free to discuss any or all of the peer support interaction. In other words, the recipient of peer support does not need your permission to reveal any information you provided. This includes anything that you said and anything that you did, and this information can go anywhere. Bottom line: <u>be professional</u>.

What do I do if a person confesses to a crime or talks about criminal behavior during a peer support interaction?

To answer this question fully would involve addressing all possible combinations of several variables. For our purposes, suffice it to say that in this situation, peer support team members should contact the TF MTM or IST MOFR immediately. The appropriate action will then be decided upon and implemented. This is why it is important to discuss the limits of confidentiality before talking about anything else!

Confidentiality

Some information discussed in peer support interactions cannot be held in confidence. PSP confidentiality applies only when trained and officially designated peer support providers are functioning in their official capacity as PSP members Policy-based peer support team confidentiality, and its limits, are defined by most state laws and administrative regulations. Per FEMA OCC, there is the potential in formal Federal investigations for courts to subpoena individuals involved in peer support. This is anticipated to be a rare circumstance.

Limits of Confidentiality / Duty to Report or Take Action

Communications that are not included in the privilege of confidentiality for PSP members:

- The individual expressed the intent to hurt themselves
- The individual expresses the intent to hurt others

Information discussed in peer support interactions can be shared with the task force Medical Team Manager (MTM) or the IST Medical Officer (MOFR) immediately if coordination of resources or general guidance is needed.

Routine Functioning Difficulties

US&R Physical/Psychological Primary Danger and US&R Secondary Danger

The primary danger of search and rescue has two components: (1) physical danger and (2) psychological danger.

Physical primary danger: The inherent, potentially life-threatening risks of the job such as working in toxic or austere environments, confronting extreme heat, long work cycles, emergency vehicle operation, and being targeted by unhappy citizens or extremists.

Psychological primary danger: Related to but distinguishable from physical primary danger. It includes the increased probability that US&R members will be exposed to critical incidents, work-related cumulative stress, and human tragedy. This higher probability of exposure results in an increased likelihood of psychological traumatization and stressor-related impacts.

Another aspect is the **secondary psychological danger**, often unspecified and seldom discussed. It is the idea that "asking for help" is associated with "personal and professional weakness." This secondary danger has been implicated in the startling frequency of first responder suicides. Some first responders choose suicide over asking for help.

The Ways that Stress Manifests in General Distress/Dysfunction

Due to the nature of our work as US&R members, chronic stress, trauma exposures, and alternative working hours (e.g., shift work) can produce an environment where psychosocial dysfunction is more frequent. These problems be demonstrable in several ways:

General mood distress: Symptoms include loss of motivation, loss of pleasure in previously enjoyable activities, physical exhaustion, sadness, hopelessness, excessive worry, difficulty concentrating. Determine the severity and duration of these experiences to decide if higher care is needed. The PhQ-9 is a useful tool (https://www.mdcalc.com/calc/1725/phq9-patient-health3-

questionnaire9) and can be used to guide the conversation rather than having the individual formally fill it out. A score of 9 or higher indicates a need for referral. **Any suicidal ideation** also indicates a need for higher care, which would occur on the PHQ-9 in response to question 9.

- **Relationship strain:** Irregular work schedules, long hours, campaign incident responses, and exposure to traumatic events can strain relationships with family members, partners, and friends.

Excessive spending/Financial difficulties: Stress may push individuals to escape discomfort through excessive spending.

- **Pornography:** Frequent use of pornography may be a coping mechanism.
- **Disruptive behaviors:** Stress and functioning difficulties can lead to disruptive behaviors at work.
- **Irritability and anger:** As a result of difficult workplace exposures, irritability and anger may arise and disrupt relationships.
- **Isolation and stigma:** Feelings of isolation or stigma when seeking help for mental health issues can prevent accessing needed support.
- **Alienation from community:** Sometimes, in the context of caring for patients and problems in one's own community, feelings of alienation and isolation can arise between the first responder and the community.

Alcohol and substance abuse: Some US&R members may turn to alcohol or drugs as a coping mechanism. Not only is this self destructive and dangerous on deployment, but it also violates the US&R Code of Ethics.

- **Difficulty coping with trauma:** Witnessing traumatic events or experiencing job-related injuries can lead to maladaptive coping strategies.

Traumatic Stress Reactions

US&R members are at increased risk for traumatic stress reactions due to occupational exposures to chronic stress and trauma.

Definition of Traumatic Event

The DSM-5 defines a traumatic event as any of the following:

- Experiencing or witnessing actual or threatened death, serious injury, or sexual violence.
- Directly experiencing the traumatic event.
- Witnessing the traumatic event happening to someone else.
- Learning that a traumatic event occurred to a close family member or close friend.
- Experiencing repeated or extreme exposure to details of the traumatic event.

These criteria are used in the diagnosis of trauma-related disorders such as PTSD within the DSM-5 framework. Not all individuals exposed to traumatic events will develop PTSD, but the experience can significantly impact mental health and well-being, even if in a temporary fashion.

Traumatic stress reactions include four symptom clusters:

1. Intrusion symptoms:
    - Recurrent, involuntary, and distressing memories of the traumatic event.
    - Distressing dreams related to the traumatic event.
    - Flashbacks.
    - Intense or prolonged psychological distress when exposed to cues that resemble the traumatic event.
    - Physiological reactions to reminders of the traumatic event.
2. Avoidance symptoms:
    - Efforts to avoid thoughts, feelings, or conversations associated with the traumatic event.
    - Avoidance of activities, places, or people that remind the individual of the traumatic event.
    - Difficulty remembering important aspects of the traumatic event.
    - Loss of interest in activities previously enjoyed.
    - Feeling detached or estranged from others.

    - Restricted range of affect or inability to experience positive emotions.
3. Negative alterations in cognition and mood:
    - Persistent and distorted negative beliefs about oneself, others, or the world.
    - Persistent negative emotional state.
    - Diminished interest or participation in significant activities.
    - Feelings of detachment or estrangement from others.
    - Persistent inability to experience positive emotions.
4. Alterations in arousal and reactivity:
    - Irritable behavior and angry outbursts.
    - Reckless or self-destructive behavior.
    - Hypervigilance.
    - Exaggerated startle response.
    - Difficulty concentrating.
    - Sleep disturbances.

A person can have some of these symptoms without meeting full criteria for PTSD. In the immediate aftermath of a specific traumatic event (first 30 days), it is not abnormal to experience traumatic stress symptoms – which we call 'acute stress reactions'. The extent to which these symptoms alter or impair occupational and social functioning is a key determinant of whether higher levels of support or intervention are needed.

Mood / Depression Screener

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

https://www.mdcalc.com/calc/1725/phq9-patient-health-questionnaire9

Suicide Risk

Purpose

This outline provides guidelines for peer supporters to identify, intervene, and support fellow US&R members at risk of suicide. It outlines procedures for assessing suicide risk, facilitating appropriate interventions, and accessing resources for crisis management and suicide prevention.

Scope

This outline applies to all peer support personnel who may encounter fellow US&R members experiencing suicidal thoughts or behaviors.

Outline

Crisis Intervention and Support

Peer supporters must have a special understanding of suicide prevention, crisis intervention, and mental health first aid to equip them with the knowledge and skills to effectively support individuals at risk of suicide.

Assessment and Identification

- Peer support providers should be vigilant for signs and symptoms of suicide risk, including verbal cues, behavioral changes, and expressions of hopelessness or despair.

If a fellow US&R member discloses suicidal thoughts or behaviors, peer supporters should take the disclosure seriously and initiate a suicide risk assessment involving the relevant MTM and or IST MOFR immediately.

Seek to identify if a fellow US&R member has a family history of suicide, recent close friends who have committed suicide, or a personal history of suicide attempts.

If the individual is deemed to be at imminent risk of harm, take immediate action to ensure their safety, including contacting emergency services, the TF MTM, and/or the IST MOFR. This reinforces why PSPs should work in pairs.

- Provide immediate emotional support, validation, and empathy to the individual experiencing suicidal thoughts or crisis.

- Encourage the individual to talk openly about their feelings, concerns, and reasons for living while maintaining a nonjudgmental and supportive stance.

Referral and Follow-Up

Facilitate referrals for further assessment and treatment through the TF MTM or IST MOFR.

- Follow up with the individual regularly to monitor their well-being, provide ongoing support, and ensure compliance with treatment recommendations.

Once the US&R member returns home, continued follow-up may occur but is not expected. Any referrals or needs should be coordinated with the members' home agency and the members should be encouraged to make contact with their own peer support providers, if available.

Interaction Reporting

De-identified documentation (namely the number of interactions) may occur on the ICS 214 form.

Resources

Take advantage of opportunities for ongoing training, supervision, and consultation to enhance knowledge and skills for peer support.

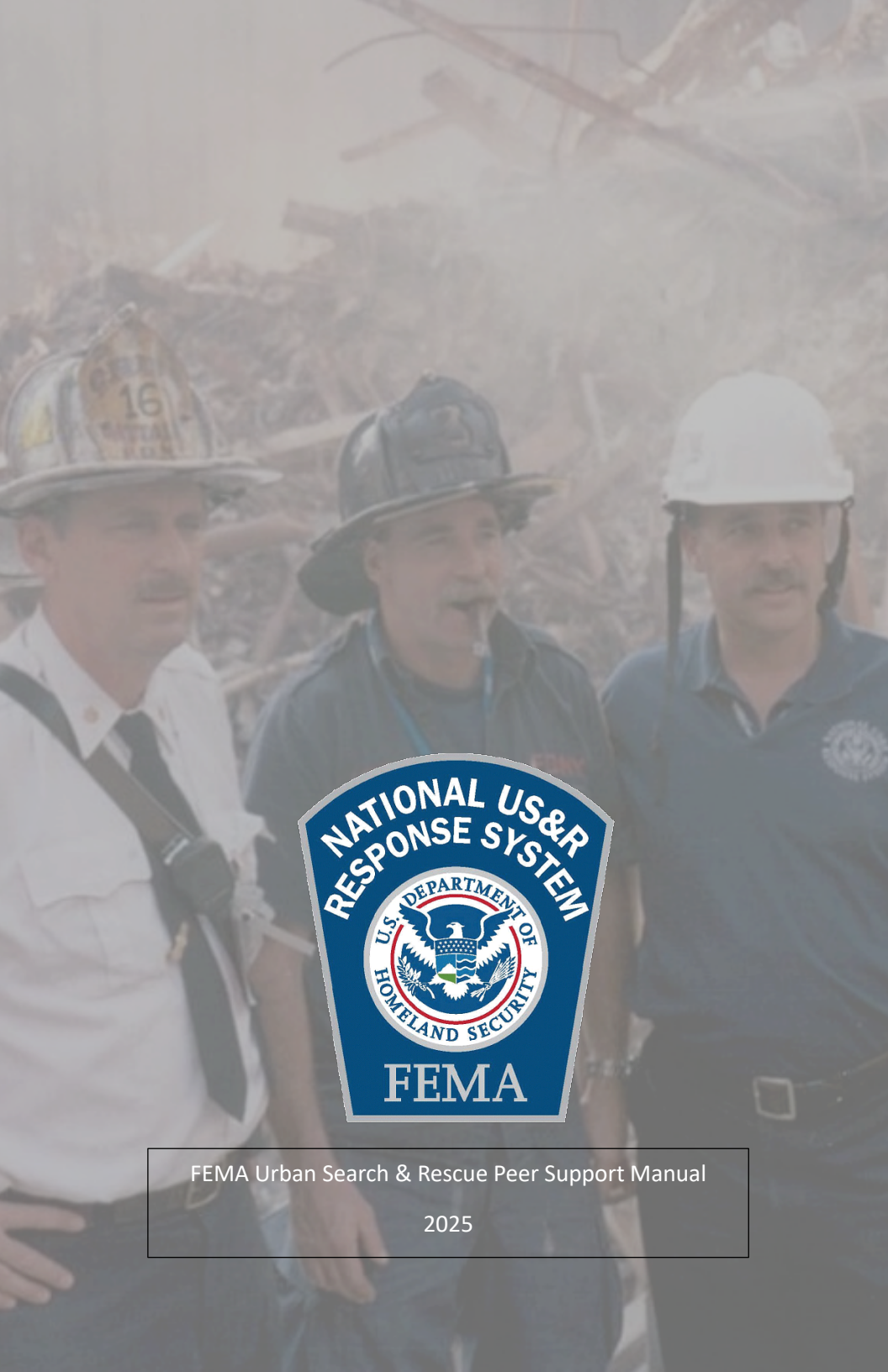
Referral Processes

Referral Process for Individuals Who Need Non-Crisis Support

- Consultation with TF MTM or IST MOFR for external referral needs.

Referral Process for Individuals in Crisis

- Consultation with TF MTM or IST MOFR for immediate referral needs. This may involve local law enforcement based on situation and intent.



FEMA Urban Search & Rescue Peer Support Manual

2025

Appendix H- BH AHG Timeline and Decisional Process

The following is a list of timelines for the US&R Behavioral Health Ad Hoc.

Prior to 2023 - The identified need for a recognized systematic approach to behavioral health for the US&R System was recognized throughout multiple deployments and the lack of a formalized approach.

12/05/2023 - GM2023-033 - USR System Member Peer Support Survey distributed

3/14/2024 - GM2024-005 - Advisory Organization - Solicitation for Behavioral Health (BH) Ad Hoc Group (AHG)

4/18/2024 - Chair and Co-Chair of the BH AHG selected

4/26/2024 - GM2024-010 - National US&R Response System Strategic Plan 2024-2027 published with performance measures: 1.3.1.1; 1.3.1.2; 1.3.1.3; 1.3.1.4; and 1.3.1.5 identifying System-level behavioral health responsibilities.

5/30/2024 - GM2024-019 - Advisory Organization - Behavioral health Ad Hoc Group distributed with the formal selection of members and identifying overall objectives and plan.

6/14/2024; 6/28/2024; 7/12/2024; 7/26/2024; 8/9/2024; 8/23/2024; 9/6/2024; 9/20/2024; 10/18/2024; 11/1/2024; 11/15/2024; 12/6/2024; 12/20/2024; 2/7/2025; 2/21/2025; 3/7/2025; 3/21/2025 - BH AHG 1.5 hour meetings

7/17/2024 - GM2024-025 - Behavioral Health Interim Plan published

1/8-10/2025 - BH AHG in-person meeting at the US&R warehouse

2/7/2025 - Finalization of US&R Documents and Solicitation for 21-day review finalized

XXXX - GM2025-XXX - 21-day Review of BH AHG documents

XXXX - Review and adjudication of 21-day review comments

XXXX - Finalization of all documents and submission to the Advisory Org Chair and Deputy Chair