MENTAL HEALTH RESOURCE AND RESPONSE GUIDE

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Prepared by

the

First Responder Mental Wellness Response Subcommittee

of the

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Executive Summary

Every first responder can vividly remember at least one "bad" call that lingers in their mind. These significant incidents can impart a painful perspective that can affect the first responder immediately, or later in their personal and/or professional lives. This can compound and have cumulative effects on personal and work life. In the past, first responders were deemed "weak" if they talked about the feelings they were having or the problems they may be experiencing due to their work environment. Unfortunately, many first responders have developed substance misuse issues that may have a mental wellness component or ultimately found themselves embattled with the struggle of suicidal ideation that can potentially lead to the first responder tragically ending his or her own life. Historically, suicide, post-traumatic stress, and catastrophic addictions have become an epidemic that is taking the lives of our fellow first responders. Florida Chief Financial Officer and State Fire Marshal Jimmy Patronis called Post Traumatic Stress Disorder (PTSD) a "hidden killer" of first responders. Only recently has the vast number of suicides become known and openly discussed. Some organizations actively track the suicides of first responders. Law enforcement officers and firefighters are more likely to die by suicide than in the line of duty. Furthermore, EMS providers are 1.39 times more likely to die by suicide than the general population. While some organizations actively track the suicides of first responders, currently no national systematic tracking system exists, and statistics are thought to be underreported.

According to the CDC, first responders, including law enforcement officers, firefighters, emergency medical services (EMS) professionals, and public safety telecommunicators, are crucial to ensuring public safety and health. First responders may be at elevated risk for suicide because of individual characteristics, the environments in which they work, their culture, and occupational and personal stress. This stress can be acute (associated with a specific incident) or chronic (an accumulation of day-to-day stress). Occupational stress in first responders is associated with an increased risk of mental health issues, including hopelessness, anxiety, depression, and post-traumatic stress, as well as suicidal behaviors such as suicidal ideation (thinking about or planning suicide) and attempts. Even during routine shifts, first responders can experience stress due to the uncertainty in each situation. Relationship problems have also been linked to a large proportion of suicides among the general population (42%). Because first responders can have challenging work schedules and extreme family-work demands, stress caused by relationship problems may also be magnified in this worker group.

First responders and other professionals who experience trauma are four to five times more likely to develop PTSD compared to the general population. When not properly addressed, the results can be tragic, as shown in a study out of Florida State University, *A systematic review of suicidal thoughts and behaviors among police officers, firefighters, EMTs, and*

paramedics. (Stanley IH, Hom MA, Joiner TE, 2016)

- Nearly half the firefighters – 46.8 percent – had thought about suicide.
- 19.2 percent had suicide plans.
- 15.5 percent had made suicide attempts.
- 16.4 percent made non-suicidal self-injuries.

In other studies, such as An analysis of suicides among first responders: Findings from the National Violent Death Reporting System, 2015 – 2017, findings were similar. (Carson, L. M., Marsh, S. M., Brown, M. M., Elkins, K. L., & Tiesman, H. M, 2023)

Mental health can be affected by a single incident such as a death of a child or a co-worker's suicide, or by a large-scale traumatic incident. During emergencies, disasters, pandemics, and other crises, stress among first responders can be magnified. Natural disasters, such as Hurricane Michael in 2018, the Surfside building collapse in 2021, or Hurricane Ian in 2022 which all resulted in devastation, such as deaths to civilians, major structural damage, flooding, storm surge, and wind damage, impacted first responders both physically and emotionally.

Following the Pulse Nightclub and Stoneman Douglas High School shootings, Florida legislators listened to the needs of first responders and unanimously passed S.B. 376, and subsequently Chapter 112.1815, Florida Statutes. Governor Scott signed the bill which extended workers compensation coverage to first responders with work related PTSD. In short, the law extends medical and indemnity benefits to first responders, with the sole diagnosis of PTSD without the need for an accompanying physical injury. This law, known as the PTSD Bill, went into effect on October 1, 2018. Now, both medical and indemnity benefits may be recovered for those defined by the law as a first responder, and if they personally hear or see a qualifying event. In addition, the law requires that "an employing agency of a first responder, including volunteer first responders, must provide educational training related to mental health awareness, prevention, mitigation, and treatment." Although the PTSD bill is an extremely important piece of legislation put in place to help support our first responders, the goal of this program, and programs like this one, is prevention.

In December 2018, the Florida Fire Chiefs Association (FFCA), Florida Professional Firefighters (FPF), State Fire Marshal's Office, Florida Firefighters Safety and Health Collaborative (FFSHC), and the International Association of Fire Fighters (IAFF), which represented all stakeholders in the area of the Safety, Health, and Wellness, convened to form the **First Responder Mental Wellness Response Subcommittee** under the Florida Joint Council of Fire and Emergency Services. This team recognized the need for an ad hoc working group to ensure every agency has access to mental wellness resources when

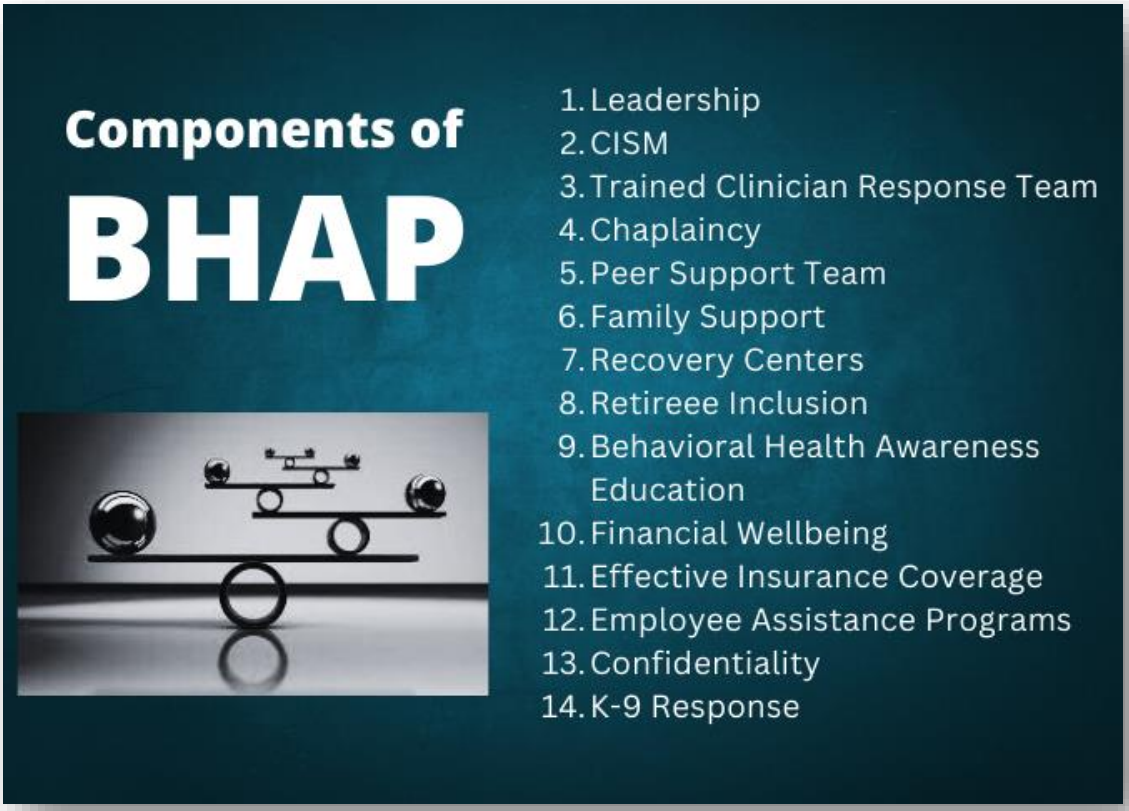
needed. A list of qualified mental wellness resources was identified, and a crosswalk of the resources was completed. The result was a list of deployable mental wellness Florida-typed resources that are incorporated into the Statewide Emergency Response Plan (SERP). This action allows for early assessment, deployment, and sustainability of mental wellness resources that directly benefit any agency or first responder.

This guide is crafted as a resource for organizations and individuals to be utilized in several ways, including prevention, early intervention, post intervention, as well as a guideline for deployment, all of which includes a path towards post-traumatic growth (PTG). Post-traumatic growth is defined as a positive physiological, as well as psychological, change that individuals may experience after a crisis or traumatic event. It is a path to grow from experiences associated with daily life and your profession. PTG speaks to long term growth from these crises or traumatic events rather than long term diminishment.

Behavioral Health Access Programs (BHAP)

Behavioral Health Access Programs (BHAP) are comprehensive, integrated, multicomponent, systematic programs for employee mental health/wellness and crisis intervention.

The purpose is to provide education, support, assessment, and intervention for employees who may be exposed to and/or affected by behavioral health issues. A comprehensive BHAP includes prevention, early intervention, treatment, and postvention in addition to crisis intervention. Examples of BHAP components may include the following:



BHAP has proven to be effective in providing guidance during assessment, basic counseling, and crisis intervention. Having a healthy workforce is the main goal behind creating a Behavioral Health Access Program. First Responders dedicate much of their careers to training and perfecting their trade. This is done in the hope that they can and will make well-informed decisions when faced with unique, challenging, and sometimes life-or-death situations. Simply put, the reason first responders train is to remain safe. When investing in a BHAP, members will be better equipped to handle the hard circumstances by utilizing these tools. BHAPs can help to reduce turnover and increase sustainability, thus

decreasing onboarding and training costs and provide a more experienced workforce. Sick leave use is another area in which often yields reductions. Members in a healthier state of mind and body are often more apt to be at work, reducing sick leave usage. The external customer will also benefit from members improving their mental wellness. A healthy workforce directly correlates to an increase in customer satisfaction. Lastly and most importantly, the creation of a Behavioral Health Access Program could prevent loss of life due to suicide by members. A complete guide to developing and implementing a comprehensive BHAP may be downloaded from the 2nd Alarm Project website, http://peersupport.2apcontacts.org/toolKit.

Debilitating Critical Incident(s), or DCI, can be a single acute incident or the cumulative effect of multiple traumatic incidents that may be a contributing factor to the first responders' transition from the acute stress injury phase to functional decline. Organizations that experience the immediate effects of a DCI and require immediate intervention should contact their BHAP Coordinator, Safety Health and Wellness Officer, or the local victim assistance specialist (commonly located within the local law enforcement agency) or:

The numbers below exist at the time of the preparation of this document and may change from time to time.

- **National Suicide Prevention Lifeline** **988**
- **2nd Alarm Project** **https://2ndalarmproject.org/**
- **Redline Rescue/Blueline Rescue** **https://redlinerescue.org**
- **UCF Restores** **https://ucfrestores.com/**
- **Copline** **1-800-COPLINE (267-5463)**

Examples of a DCI include, but are not limited to (A DCI is very personal in nature and will vary):

- Significant injury or death of a member of the organization
- Pediatric injury or death
- Large Scale/Long Term Event with or without loss of life (natural, man-made, or technological disaster, ASHER event, etc.)
- Multiple youth fatalities or violence to a minor
- Events with severe operational challenges
- Line-of-duty death or line-of-duty injury
- Officer-involved in a shooting
- Off-duty death, suicide, homicide, or injury

- Events with multiple or mass casualties
- Events when the victim(s) is (are) known
- Events with excessive media interest
- Serious injury or death of a civilian resulting from organizational operations (e.g., vehicle accidents or structure fires)
- Any incident that could perceivably cause an emotional impact
- First responder involved in an accident with traumatic injuries

The best approach for organizations is to establish BHAP Structure before any DCI. Early establishment of the BHAP also fulfills requirements of F.S. 112.1815 for agencies to provide educational training related to mental health awareness, prevention, mitigation, and treatment. Once in place, the BHAP components will provide education, support, assessment, and intervention for first responders and other employees adversely affected by Debilitating Critical Incidents. The benefits of a developed and sustainable BHAP program include a reduction in symptoms of post-traumatic stress, leads toward post-traumatic growth, quicker return to normal productive functioning, increased job satisfaction, reduced worker's compensation claims, and enhanced group cohesion.

As shown in the figure above, BHAP resources include but are not limited to:

- Critical Incident Stress Management (CISM)
- Peer Support / Trained Peer Support / K-9 Crisis Response
- Family Support
- Chaplaincy
- Retiree Support Programs
- Safety, Health, and Wellness Committee
- Behavioral Health Awareness Education
- Comprehensive Health Insurance Coverage (with behavioral health benefits) provided by employer
- Financial Health Education
- Culturally competent Employee Assistance Programs
- Trained, Culturally Aware Clinician Response Team (CRT)
- Vetted Recovery Centers

See Appendix A for a definition of those components.

The components listed above are a representation of a comprehensive BHAP program. It is recommended that organizations identify what components they are lacking and then build those resources into their program as resources become available. If an organization does not have sufficient access to resources, they should consider collaborating with surrounding agencies to share resources to better meet the needs of a comprehensive BHAP. This is not an all-or-nothing program. Organizations must build the program to meet the culture of the organization.

Any of these BHAP components should be open to all active and retired first responders, as well as their caregivers and family support systems. These resources can be made available to all public servants.

Request for Mental Wellness Resources

After a DCI, some departments will implement BHAP components (CISM, Peer Support, etc.) to effectively assist affected members.

Organizations that lack sufficient resources or need additional resources may request deployable mental wellness typed resources via their fire chief or designee by accessing the Statewide Emergency Response Plan (SERP) through their SERP Regional Coordinator or referring to the FFCA Statewide Emergency Response Plan.
https://www.ffca.org/assets/docs/SERP/SERP%20Plan%20Approved%207-16-2021.pdf

Deployable mental wellness typed resources include:

- Critical Incident Stress Management Teams (Mitchell Model, ICISF)
- Peer Support (IAFF, Illinois Peer Support, North Carolina Peer Support, Nova Southeastern University Firefighter Intervention and Response Support Team, UCF REACT)
- Chaplaincy
- Clinician Response Team (CRT)
- K-9 Crisis Response
- Incident Command Support – IMT Support
    - Incident Management Team (IMT)
    - Incident Support Team (IST)

See Appendix B for a detailed listing of these deployable resources.

If you require assistance, requests should go through the County Emergency Manager to the State Emergency Operations Center (SEOC) to the SERP Chair/State Coordinator. At the time of publication of this document, this information is as follows:

TJ Lyon | OPS Governmental Analyst Ⅱ
FFCA SERP-Emergency Response Committee Chair
Bureau of Fire Standards & Training
Florida State Fire College
11655 N.W. Gainesville Road
Ocala, Florida 34482-1486
USNG: 17R LN 84075 44020
tjlyon@me.com

All requests and subsequent deployments shall follow the established guidelines and rules laid out in the current FFCA State Emergency Response Plan (SERP) and State Fire Marshal, ESF 4&9 Resource Management Plan.

Like the Incident Command System, the mental wellness typed resources are scalable to meet the needs of the type and severity of an incident. Resource requests can be as small as a single resource (Chaplain or single Peer Supporter) or as complex as multiple team deployments along with a Team Leader, (Clinician Response Team with Peer Support members and a Team Leader). In addition, the requesting agencies should identify the timeline when the requested resources are needed (i.e., deployed within 24 hours for a total duration of 3 days), and a point of contact.

At the local level, if a municipality needs Mental Wellness support, they first make the request to the County Emergency Management agency. As with other needed resources, the County EM in the local EOC would make the request via the State WebEOC Resource Requests/Task Assignments template to the State Emergency Operations Center (SEOC). The SEOC Operations Section and Emergency Services Branch will task to State ESF 4&9 for coordination through the FFCA SERP.

The agency deploying the requested resources may contact the requesting agency to complete a needs assessment to determine the organization's size, members affected, the effectiveness of existing wellness programs, the type of incident encountered, and possible resources needed.

The Team Leader (if deployed) will coordinate any logistical needs and establish a schedule for the requested deployed resources. No mental wellness resources will be deployed without the request and approval of the requesting Chief, Designee, State ESF 4&9 ECO, or SERT Chief in the SEOC.

While mental wellness resources operate under strict confidentiality, as defined by state statute, the agency head will be updated as to the general progress of the scheduling process and any outstanding logistical needs.

Deployed Mental Wellness Resources

Once deployed, the requested mental wellness resources will:

- Provide education and materials specific to the event and location. These assets will be comprised of the affected Organization's vetted local resources.
- Promote trust, allow anonymity, and preserve confidentiality for employees utilizing the program.
- Attempt to identify any members of the affected organization that may have immediate needs that require follow-up or ongoing support. These may be extended to the members' families as well.

The Team Leader will:

- Establish a schedule to reach each shift/station and any other work environments.
- Ensure that, once deployed, resource team members will be self-sufficient and will not adversely affect the impacted organization(s).
- Confirm with the Chief or designee as to the finalized schedule.
- Communicate with all concerned about any unresolved issues or future suggestions when the process is complete.
- Debrief deployed wellness team members and provide demobilization orders.
- Track the locations, number of personnel contacts, and activities

See Appendix C for a Team Leader Checklist

After Action Report:
Following each deployment, with the assistance of the County and Regional SERP Coordinator(s), resources are encouraged to provide an After-Action Report (AAR) to the State SERP Coordinator and the State Fire Marshal's Office. This should be accomplished as soon as practical but not longer than 90 days post- deployment unless otherwise specified. The AAR is intended to highlight "lessons learned" that can be provided to all members of the SERP. There is no standard format, but the following categories are suggested: Activation/Assembly; Travel; On Scene Operations; Demobilization; Return to Readiness/Reimbursement.

Upon completion of the deployment, the Team Leader will:

- Compile information gathered from the teams to develop an ongoing needs assessment for the affected department. This will include recommendations for follow-up, administrative adjustments, and any other pertinent considerations.
- Provide a written analysis specific to their job function within the deployment that will

include overall activities (number of first responders attending, number of sessions held, etc.) as well as Strengths, Weaknesses, Opportunities, and Challenges for the operation.

Mental Wellness Response Team (MWRT) and Mental Wellness Typed Resources

After a DCI, some departments will implement BHAP components (CISM, Peer Support, etc.) to effectively assist affected members.

Organizations that lack sufficient resources or need additional resources may request deployable mental wellness typed resources through the FFCA Statewide Emergency Response Plan (SERP) and their SERP Regional Coordinator.

Mental Health Resource and Response Guide Procedure Predetermined Response Plan

The organization having jurisdiction should evaluate the need for the deployment of resources after a DCI occurs. If the determination is made that BHAP components are needed, the recommendations for deployment levels below may serve as guidance and may be adjusted based on the needs assessment.

An MWR will be classified by different levels depending on the number of responders, identified needs, and if necessary, the geographical location of the event. A forward MWRT may be deployed to help determine the level of resources needed.

MWRT Level 1 (0-10 responders):

- One type-2 CISM Team
- One type-2 Peer Team
- One type-3 Chaplain
- One type-3 CRT member
- One type-3 K-9 Resource

MWRT Level 2 (11-50 responders):

- One type-1 CISM Team
- One type-2 CISM Team
- Two type-1 Peer Teams
- One type-2 Chaplain group

- One type-2 CRT
- One type-2 K-9 Resource
- One type-3 TL

MWRT Level 3 (51-100 responders):

- Two type-1 CISM Teams
- Two type-2 Peer Teams
- One type-3 Peer Team
- One type-2 Chaplain group
- One type-1 CRT
- One type-2 K-9 Resource
- One type-1 K-9 Resource
- One type-2 TL

MWRT Level 4 (100-500 responders):

- Four type-1 CISM Teams
- Three type-2 CISM Teams PRN type-3 CISM single resources per IC
- Five type-1 Peer Teams and PRN type-3 single resource peers per IC
- Two type-1 Chaplain Groups
- Two type-1 CRT and PRN type-3 as requested by IC
- Two type-1 K-9 Resources
- Four type-1 TLs

MWRT Level 5 (500 or greater responders or when regional resources are overwhelmed or exhausted):

- Six type-1 CISM teams
- Five type-2 Peer Teams
- Three type-1 Chaplain Groups
- Three type-1 CRT and PRN type-3 as requested by IC
- Four type- 1 K-9 resources
- Eight type- 1 TLs

State of Florida Recognized Mental Wellness Task Force Recommended Activities

The following are recommendations for a State of Florida Recognized Mental Wellness Task Force to adopt, pre-deployment, to ensure proper levels of mental wellness support are part of the task force.

- Recruit team members through the pre-existing network in their region to be part of the task force.
- Once built, the Team Lead for that region may:
    - Implement Resiliency Training to the Task Force teams to lay the foundation of a successful mission as well as return.
    - Take part in Task Force Team training to better understand the functions of the team as well as build a rapport with the team.
    - Utilize the preparation period to ensure that the Team Members are current with training including the appropriate ICS courses for their role.
    - Coordinate with other regions regarding training and follow-up procedures.

- Benefits of having trained peer support members or other mental wellness resources embedded with a task force before a deployment may accomplish the following:
    - Peer support members know what and how a Task Force accomplishes their mission.
    - Peer support members will have trained on these deployments before the incident, creating a higher level of readiness.
    - Peer support members will understand the importance of not removing a task force member from their operational assignments while addressing mental wellness needs.
    - Post deployment follow-up is one of the most crucial functions an embedded peer support member can perform. An embedded peer support member will allow for a more consistent approach and better monitoring of task force members.
    - These peer support members may help develop and deliver resiliency training to the Task Force Teams pre-deployment.

If a task force does not have available embedded peer support members or other mental wellness resources, they are expected to follow the typical outreach model outlined in this document.

Demobilization

The purpose of a Mental Wellness demobilization plan sets forth the process and documentation required to be submitted prior to release from operations. The concept is for Mental Wellness to remain in operations until all response operations are completed, and the overall Incident Commander and the Mental Wellness Incident Management Team concur on a certain date and time.

Once the deployed Task Force(s) have been released from operations and demobilized, the Peer Teams will perform outreach to facilitate the mental wellness needs following their return home.

See Appendix D for an example of the demobilization plan that was used after Hurricane Ian.

Appendix A – Definitions

Behavioral Health Awareness Education: Educational components offered to the first responder(s) should cover common mental health issues specific to first responders. These programs may include awareness of the signs and symptoms of stress as well as discussion of the types of resiliency factors and how they can be developed. Leadership-level components may also be offered to cover the scope of the mental wellness-related issues, agency culture, reducing employee stress, policies, identifying employees in crisis, and how to assist those in need of assistance.

BHAP Leadership: The organization's leadership should be accessible and open to supporting employees and their families' mental wellness needs. This includes demonstrating empathy and concern for these individuals, referring them to the various options available within BHAP, and creating a trusting environment and workplace culture.

Chaplaincy: Chaplains in first responder organizations provide pastoral/spiritual crisis intervention and personal counseling to first responders and other staff members. Their main purpose is not limited to helping first responders and department members/families in the event of an injured or killed first responder. They are also available to personnel for grief counseling. They lend an ear to those who need to talk about something that is bothering them, such as physical or emotional stress.
A chaplain's goal is to aid, comfort, and provide spiritual care to first responders, their families, and crisis victims and refer, when appropriate, to vetted resources to provide assistance in the recovery cycle. While a chaplain will bring their faith traditions and beliefs as a basis for their chaplaincy, they are able to connect with and support those of faith or of no faith. Fire chaplains lend an ear to those who need to talk about challenges they are facing, professionally or personally, and do so in a confidential manner.

Critical Incident Stress Management: ICISF Trained team(s) which utilize the SAFER-R model of individual psychological crisis intervention, which serves as protocol or procedural guide to aid in conducting such individual and/or group psychological crisis interventions.

Culturally Competent Employee Assistance Programs: Employee Assistance Programs should be available to first responders and their families through a process that includes program managers knowledgeable in first 'responders' mental health professionals and effective treatment options specific to the unique first responder culture and community.

Debilitating Critical Incident/s (DCI): Debilitating Critical Incident(s) can be a single acute incident or the cumulative effect of multiple traumatic incidents that may be a contributing factor to the first 'responders' transition from the acute stress injury phase to functional decline.

Comprehensive Insurance Coverage: Effective insurance policies for first responders should include first responder-specific providers and provide the highest level of service while limiting any potential impediments to accessing clearly identified first responder-specific resources. These programs should seek out and provide a current and detailed list of culturally aware providers with tangible and validated experience working with first responders and fixed facilities with first responder-specific programs.

Family Support: Family caregivers (Spouses, Life partners, Parents, and Children) are in an ideal position to be attuned to and provide support toward identifying the need for professional care for their loved ones. Educational programs may be designed to enhance the 'caregiver's knowledge of Stress injuries/mental health-related issues specific to the first responder and develop strategies to manage conflict, prevent relapse, and promote recovery for themselves and their loved ones.

Financial Health Education: Mental wellness programs should also include components to assist individuals in feeling secure in their ability to meet ongoing financial obligations and prepare for the future. Improving financial health is a critical aspect of overall wellbeing in terms of managing stress. A state of financial wellbeing allows individuals to make choices that allow them to enjoy a better quality of life. Sharing strategies for saving and spending, preparing for emergencies, understanding a credit score, and preparing for retirement are important components of a comprehensive BHAP.

IMT: Incident Management Team (IMT): A group of ICS-qualified personnel consisting of Mental Wellness Incident Commander, Command and General Staff, and personnel assigned to other key Mental Wellness ICS Positions. The Mental Wellness Group is in the Operations Section, under the Medical Branch, working closely with Safety, to coordinate mission assignments.

IST: Incident Support Team (IST): A group Mental Wellness Qualified personnel available to provide technical assistance in the deployment of Mental Wellness resources.

K-9 Team: Therapy Dogs and their handlers are highly trained, registered, and certified. Therapy dogs and Crisis Response Canines are dogs trained to serve people other than their owners and are appropriate for use in Peer Support. During activation of a major event the K-9 teams report to the Mental Wellness coordination Group Leader for assignments and reports back daily activities and issues.

Peer Support: Peer support occurs when trained personnel provide knowledge, experience, emotional, social, or practical support to members in need. It commonly refers to an initiative

consisting of employees trained as supporters and can take a number of forms such as Peer Mentoring, Reflective and Active Listening, and Referral to professional counseling services where appropriate.

Retiree Support Programs: Mental wellness programs should be extended to include retirees who may continue to suffer from job-related stress and could benefit from positive BHAP programs. The retiree demographic can be at a higher risk of depression, substance abuse, and suicidal ideation due to a multitude of factors, including but not limited to loss of a sense of purpose, decreased activity and involvement in department-related functions/Operations, and perceived low levels of connectivity with others within the first responder community. Your retiree demographic can be an invaluable asset in areas such as peer support and the other regions pertaining to resiliency and mental wellness within your department.

Safety, Health, and Wellness Officer: The Safety, Health, and Wellness Officer manages all aspects of BHAP. The program, once up and running, requires administration, updating of information, and analysis of the effectiveness of its various components. The Safety, Health, and Wellness Officer oversees the program and leads the committee.

Safety and Health Committee: The safety and health committee is designed to bring workers and management together in a non-adversarial, cooperative effort to promote safety and health in the workplace in compliance with FL Statute 633.522

SERP: Florida Fire Chiefs Association Statewide Emergency Response Plan – State of Florida guiding document to provide for the systematic mobilization, deployment, organization, and management of fire-based resources throughout Florida. The SERP also references deployments through the National Emergency Management Assistance Compact (EMAC) between states, in assisting local agencies in mitigating the effects of any large-scale disaster. The local fire rescue agency is the first tier of response in the event of a natural, man-made or technological major emergency or disaster.

Trained, Culturally Aware Clinician Response Team (CRT): Interagency team that has been trained through cultural awareness program. The CRT provides assessment, treatment, and educational services when first responders are experiencing crisis symptoms that may put them at great risk for mental health issues.

Vetted Recovery Centers: Fixed facility centers that provide first responder-specific treatment care programs geared toward successful recovery from substance abuse, PTSD, and other co-occurring behavioral health-related issues.

Appendix B – SERP Mental Wellness Typed Resources

Critical Incident Stress Management Teams (Mitchell Model ICISF)

Description	Responsible for mitigating severe stress and enhancing psychological resilience among emergency responders.
Education/Training	Completion of Mitchell Model ICISF course, and ICS 100, 200, and 700
Resource Category	Medical and Public Health
Resource Kind	Single Resource/Team
Overall Function	• Assesses and prioritizes the behavioral health needs of first responders to an event. • Provides peer-led, mental health-informed interventions to mitigate common stress responses and facilitate return to work. Interventions include: - Individual psychological first aid or crisis intervention - Education regarding normal stress responses and coping strategies for psychological resilience through informal groups. - Group interventions to discuss responder experiences and elicit social support. • Provides referrals to community resources for follow-up or to address the need for higher levels of care.
Ordering Specifications	• Discuss logistics for deploying this team, such as security, lodging, transportation, and meals, prior to deployment. • The team typically works 12 hours per shift, is self-sustainable for 72 hours, and is deployable for up to 14 days. • This team serves responders in multiple groups, accesses multiple sessions, or in one-on-one sessions. • Requester orders additional teams to serve larger numbers of responders.
Resource Types	Type 1 = Team, seven members, and 1 Team Leader Type 2 = Team, four members and 1 Team Leader Type 3 – Personnel, one single resource

Appendix B – SERP Mental Wellness Typed Resources cont.

Peer Support - (IAFF, Illinois Peer Support, North Carolina Peer Support, Nova Southeastern University Firefighter Intervention and Response Support Team, UCF REACT)

Description	Responsible for mitigating severe stress and enhancing psychological resilience among emergency responders.
Education/Training	Completion of coursework from any of the following agencies: IAFF, Illinois Peer Support, North Carolina Peer Support, Nova Southeastern University Firefighter Intervention and Response Support Team, UCF REACT, and ICS 100, 200, and 700
Resource Category	Medical and Public Health
Resource Kind	Single Resource/Team
Overall Function	• Assesses and prioritizes the behavioral health needs of first responders to an event. • Provides peer-led, mental health-informed interventions to mitigate common stress responses and facilitate return to work. Interventions include: - Individual psychological first aid or crisis intervention - Education regarding normal stress responses and coping strategies for psychological resilience through informal groups. - Group interventions to discuss responder experiences and elicit social support. • Provides referrals to community resources for follow-up or to address the need for higher levels of care.
Ordering Specifications	• Discuss logistics for deploying this team, such as security, lodging, transportation, and meals before deployment. • The team typically works 12 hours per shift, is self-sustainable for 72 hours, and is deployable for up to 14 days. • This team serves responders in multiple groups, accesses multiple sessions, or in one-on-one sessions. • Requester orders additional teams to serve larger numbers of responders.
Resource Types	Type 1 = Team, seven members, and one Team Leader Type 2 = Team, four members and one Team Leader Type 3 – Personnel, one single resource

Appendix B – SERP Mental Wellness Typed Resources cont.

Chaplaincy

Description	Responsible for providing spiritual and emotional support to staff, emergency responders, and the public during times of stress.
Education/Training	Ecclesiastical endorsement, 3 years fire chaplain experience, currently affiliated with a fire department, Completion of Federation of Fire Chaplains Essentials course, ICISF Critical Incident Stress management course, and ICS 100 and 200
Resource Category	Medical and Public Health
Resource Kind	Single Resource/Team
Overall Function	• Coordinates information and liaises on family support service options with other appropriate agencies • Meets with families and individuals who experience emotional or spiritual difficulties during disasters and emergency incidents • Offers guidance to staff, emergency personnel, and the public during times of stress • Works to coordinate activities and events for after-work hours for responders to ease the stresses of long work cycles • Provides discretion and confidentiality of all verbal and written documentation concerning the deceased, next-of-kin (NOK), and family members • Provides referral to other specialized resources, including behavioral health • Delivers or accompanies law enforcement during death notifications • Coordinates the inclusion of diverse cultural and religious values and traditions, as indicated by the spiritual and emotional needs of the impacted population
Ordering Specifications	• Discuss logistics for deploying this team, such as security, lodging, transportation, and meals prior to deployment. • The team typically works 12 hours per shift, is self-sustainable for 72 hours, and is deployable for up to 14 days. • This team serves responders in multiple groups, accesses multiple sessions, or in one-on-one sessions. • Requester orders additional teams to serve larger numbers of responders.
Resource Types	Type 1 = Team, seven members, and one Team Leader Type 2 = Team, four members and one Team Leader Type 3 – Personnel, one single resource

Appendix B – SERP Mental Wellness Typed Resources cont.

Clinician Response Team (CRT)

Description	Responsible for mitigating severe stress and enhancing psychological resilience among emergency responders.
Education/Training	The licensed clinical professional that are culturally aware of first responders, trauma informed evidence-based practices in the treatment of first responders and have been trained through a vetted cultural awareness program, and ICS 100, 200, and 700
Resource Category	Medical and Public Health
Resource Kind	Single Resource/Team
Overall Function	• This team provides incident-related behavioral health services to responders and families, after a disaster, which may include: - Behavioral health needs assessment - Crisis intervention - Community Outreach - Behavioral health consultation - Screening and referral, including referral for ongoing health needs or those outside of the scope of incident-related service
Ordering Specifications	• Before deployment, discuss logistics for deploying this team, such as security, lodging, transportation, and meals. • The team typically works 12 hours per shift, is self-sustainable for 72 hours, and is deployable for up to 14 days. • This team serves responders in multiple groups, accesses multiple sessions, or in one-on-one sessions. • Requester orders additional teams to serve larger numbers of responders.
Resource Types	Type 1 = Team, seven members, and one Team Leader Type 2 = Team, four members and one Team Leader Type 3 – Personnel, one single resource

Appendix B – SERP Mental Wellness Typed Resources cont.

K-9 Crisis Response (AACR – Animal Assisted Crisis Response)

Description	Responsible for coordinating and training assets for deployable canines.
Education/Training	Completion of Therapy Dog Certification, Animal Assisted Crisis Response by the FFSHC, and Peer Support Certification, and ICS 100, 200, and 700
Resource Category	Medical and Public Health
Resource Kind	Single Resource/Team
Overall Function	Response Canine handlers provide comfort, stress relief, emotional support, and crisis intervention services as Peer support for those affected by crisis or disaster.
Ordering Specifications	• This position can be ordered as a single resource, or in conjunction with a Peer Support Team. • Discuss logistics for deploying this position, such as working conditions, length of deployment, security, lodging, transportation, and meals prior to deployment. • Discuss logistics for deploying this team, such as security, lodging, transportation, and meals before deployment. • The team typically works 12 hours per shift, is self-sustainable for 72 hours, and is deployable for up to 14 days. • This team serves responders in multiple groups, accesses multiple sessions, or in one-on-one sessions. • Requester orders additional teams to serve larger numbers of responders.
Resource Types	Type 1 = Team, seven members, and one Team Leader Type 2 = Team, four members and one Team Leader Type 3 – Personnel, one single resource

Appendix B – SERP Mental Wellness Typed Resources cont.

Team Leader

Description	Responsible for coordinating deployed resources to effectively meet the needs of the requesting department.
Education/Training	Completion of Strike Team Leader coursework, and ICS 100, 200, 300, 400, and 700
Resource Category	Medical and Public Health
Resource Kind	Single Resource
Overall Function	• Leads and directs a Mental Wellness Response Team. • Manages and provides professional guidance for a team of individuals providing behavioral health interventions, psychological first aid (PFA), and referrals. • Interfaces with other public health and social service disciplines
Ordering Specifications	• Discuss logistics for deploying this team, such as security, lodging, transportation, and meals before deployment. • The team typically works 12 hours per shift, is self-sustainable for 72 hours, and is deployable for up to 14 days. • This team serves responders in multiple groups, accesses multiple sessions, or in one-on-one sessions. • Requester orders additional teams to serve larger numbers of responders.
Resource Types	Type 1 = personnel, one single resource Type 2 = Personnel, one single resource Type 3 = Personnel, one single resource

Appendix C – Team Leader Checklist

TEAM LEADER CHECKLIST

	Bring sufficient copies of any paperwork required
	Provide education and resource materials specific to the event and location. These resources will be comprised of the affected department's vetted local resources.
	Identify Ambassadors (Union representatives, retirees, etc.) that can meet the team and introduce them at each station/work location.
	Have contact information for licensed mental health professionals
	Ensure that, once deployed, resource team members will be self-sufficient and will not adversely affect the department.
	Record the name and contact information for each team member under your supervision
	Establish a schedule to reach each shift/station and any other work environments. Confirm with the Command Staff and Union representative(s) as to the finalized schedule.
	Promote trust, allow anonymity, and preserve confidentiality for employees utilizing the program
	Attempt to identify any members of the affected departments that may have immediate needs that require follow-up or ongoing support. These may be extended to the members' family as well.
	Debrief and provide materials to deployed team members at the completion of incident
	Communicate with all concerned when the process is complete as to any unresolved issues or future suggestions
	Compile information gathered from the teams to develop an ongoing needs assessment for the affected department. This will include recommendations for follow-up, administrative adjustments, and other pertinent considerations.
	Provide a written analysis specific to their job function within the deployment that will include overall activities (number of first responders attending, number of sessions held, etc.) as well as Strengths, Weaknesses, Opportunities, and Challenges for the operation.
	Ensure ICS 214 Daily Activity Logs are completed for all Team members, along with Team Roster, Emergency Agency POC, and ICS 218. Include all information required under the SERP.

Appendix D –Example of a Demobilization Plan (Hurricane Ian)

Mental Wellness Response Demobilization Plan - Hurricane IAN

Purpose - To set forth a plan to demobilize the mental wellness assets deployed the responding USAR Teams deployed to disaster-hit areas, as well as local first responders affected and overwhelmed following the impact and landfall of Hurricane Ian as a Category Four storm.

Background - On September 26, 2022, the State Mental Wellness Team (i.e., the Behavioral Health Access Program (BHAP)) was contacted regarding Hurricane Ian response and a mental wellness response component. As the storm approached, there were concerns that the storm would be a catastrophic damage event. USAR teams from across the state and nation were deployed and staged throughout the impacted and surrounding areas. In total, there were 17 USAR teams in theater along with both local, state, and federal FEMA assets. Due to the size and nature of this event, mental wellness assets for the responders were essential.

Overview – The assets consisted of a Mental Wellness Team Incident Management Team (MWT-IMT) operating in concert with the overall Hurricane Ian IMT at the Orange County Convention Center (OCCC) and five to eight peer-based strike teams located in the disaster impacted zones in and around Ft. Myers. The MWT-IMT consisted of two Incident Command Team Leads, two Logistics Planners, three Peer Support Coordinators, two Clinical Coordinators, Lead K-9 coordinator, and one Lead Chaplain. The five peer-based mental wellness strike teams consisted of 37 peer team members from various regions around the State, trained through approved training curricula, chaplains, crisis K-9 response dogs, as well as licensed professional culturally competent mental health clinicians as needed. The International Association of Fire Fighters (IAFF) also supported this mission by providing additional teams comprised of peers trained through accepted training.

Impacts- Daily briefings as part of the Incident Management Team (IMT) medical and safety branches included communication on available mental health resources, along with a printed and electronic palm card and QR code linking responders to additional resources.

The peer-based strike teams in the field were dispatched to USAR Task Force Base of Operations (BOO) locations, as well as fire stations, emergency operations centers, public safety telecommunications centers, first responder administrative buildings, and law enforcement organizations in the impacted areas.
During the visits, and as of 10/10/2022 strike teams made a total of 4,961 contacts with first responders, with 1,995 of those occurring within the fire stations and 2,966 occurring outside

the fire stations (at the BOO, other sites listed above, or at our resource store set up with essential items for responders, etc.). During these contacts, 1.8k palm cards were handed out inside the fire stations and an additional 2.9k were handed out outside of the stations at the BOO, other locations, or the store.

Starting on Friday September 30th through Wednesday October 10th mental wellness strike teams deployed were able to visit the following fire stations:

Lee County - 74 stations each visited three times throughout the county, plus dispatch centers Police Headquarters, and multiple other agencies.
Charlotte County – 37 stations each visited three times throughout the county.
Collier County – 14 stations across 3 shifts
Sarasota County – 2 Englewood stations on the south end of the county three times, with the initial goal being all stations that may have requested assistance.

Additional resources included in the palm cards are consultation phone numbers to both UCF RESTORES and 2nd Alarm Project which provide telehealth access to a culturally competent professional clinician in real time. Currently, 35 responders have used these services.

Additionally, the MWT-IMT responded to two calls from peer support personnel asking for a clinician to reach out and conduct a telehealth assessment of two SW Florida firefighters who had experienced significant personal losses and were displaying significant distress, conducted one informal debriefing of 8 National Guard personnel who unexpectedly discovered human remains during a road clearing assignment, and provided clinical consultation/ facilitated an in-person assessment of one FEMA Task Force member, who was experiencing significant distress. In this instance, the lead clinicians from the MWT-IMT worked with a licensed SW Florida clinician and arranged for this professional to conduct an in-person assessment and deliver a written report regarding the situational status back to the FEMA Medical Team at the IMT.

Demobilization- Once the deployed emergency service teams have demobilized and are no longer actively involved in the recovery efforts, the Peer Teams will perform outreach to the home agency and department leads to facilitate the mental wellness component of their return home.

This outreach will be most effective following these guidelines, but they are adjustable if additional information or needs arise.

- Peer Teams will consist of two members, both trained per the guidelines of the First Responder Mental Wellness Subcommittee of the Joint Council.
- A clinician may be attached to each task force team to mitigate any immediate needs that may arise and cannot be addressed by the Peer Team members on the scene.
- Small groups have shown to be most effective. A response of two Peer Team members for every 12-14 emergency workers may provide the best environment for a healthy post-incident outreach.
- Understanding that the processing of this incident may not occur until much later, the primary function of these teams will be to provide psychoeducation through an understanding of what mental wellness-related issues may or may not occur following this event.

Follow-up is a crucial part of any Peer Team's function. This outreach portion is not to be taken lightly and can often be the most challenging task to accomplish. The Peer Teams will attempt to provide the USAR team leaders with local resources available to them and their members. This may be through palm cards with approved resources like ***RedlineRescue.org***, or another department-specific resource. In addition, with our partners from UCF Restores, 2nd Alarm Project, and Florida DEM, State of Florida Disaster Recovery Mental Health Coordinator, to unify our mental health resources to provide both residents and first responders with mental health resources.

With the assistance of the Planning Chief and Liaison Officer, the Deployment leader will develop a timeline for the emergency services team leaders to contact their members through the guidance of a local Peer Support Representative.

This deployment will follow an ICS model, and a needs assessment will be completed before the team's demobilization.

Demobilization Plan State Teams
Tuesday Oct 11th Peer Team 1 demobilized
Wed Oct 12th Peer Team 2 and 3 demobilized
Thursday am Peer team 4 & 5 demobilized

IAFF Peer Teams
IAFF Peer Team 1 Demob on Tuesday Oct 11th
IAFF Peer Team 2 Demob on Wed oct 12th

IMT Mental Wellness Team- Demobilized on Thursday am

Appendix E – Documentation

As with all deployments, documentation is an important, required component that begins with cost estimate forms and mission orders, through 214 forms and receipts for eligible purchases, and everything in between. Deployed individuals and teams must check in with the Resource Unit Leader upon arrival, and then check out with the Demob Unit prior to leaving, utilizing Form 201. While deployed, 214 forms must be completed, and documentation must include all the appropriate information such as:

- All relevant actions throughout the deployment
- Amount of fuel and where acquired
- Mileage records
- Where personnel are staged lodged
- Where meals are obtained

This gathering of information needs to be accomplished by the deployed personnel and/or team leadership at the time of occurrence or will be forever lost.

Without proper documentation many claims can and will be denied for reimbursement among other possible implications. The post response recovery claims, processing, and financial activities are outlined in other documents.

Appendix F - K-9 Deployment Standards Suggestions and Best Practices

Below are the current suggested standards for Peer Support K-9 team deployment. They include training and certification for both the canine and Peer handler to function as a tandem team (K-9 and Peer) as part of the Mental Health deployment response.

Type 1 Handler

1. National Certified Registered Therapy Dog Certification
2. CISM **and** Peer Support Certificate
3. 2-hour Self Care Certificate class (Resiliency, Boulder Crest Struggle Well)
4. Animal assisted Crisis Response K-9 course (Florida Firefighters Safety and Health Collaborative)
5. K-9 First Aid and CPR
6. ASIST (Applied Suicide Intervention Skills Training) or equivalent certificate

Type 2 Handler

1. National Certified Registered Therapy Dog Certification
2. Animal Assisted Crisis Response K-9 course (Florida Firefighters Safety and Health Collaborative)
3. Either CISM or one of the acceptable Peer Support models

Type 1 handlers will be called and utilized first for deployments. If no Type 1 handlers are available, a Type 2 handler will be called and can pair with a Type 1 handler if possible. Type 2 handlers will become Type 1 handlers when all required certifications are obtained.

Both require the Crisis Response K-9 course. Suppose deployment is needed as the assets are being trained and don't yet have the Crisis Response K-9 course. In that case, a Nationally Registered Certified Therapy certification and either CISM or Peer Support certification can be utilized at the discretion of the Statewide K-9 Coordinator and Chris Bator.

Explanation of Suggestions

A. **National Registered Therapy Dog Certification instead of a certificate of training.**

1. The certification provides liability insurance at a low cost. 30-100 per year, depending on which organization is used.

2. It is the requirement for AACR per the national standards

3. Evaluation and ongoing requirements for visits using the canine

4. Accessible to everyone in the state

5. Redundancy in safety as far as multiple evaluations by industry professionals as well as the K-9 Coordinator for aggression or behavior issues.

6. Re-certification is required. This is important as it ensures the tandem team has the experience, knowledge, and skills development. Some departments have very active peer support teams, but not all. If the team is not active in peer support, they will still need to be active as a therapy dog team.

7. Health records and vaccinations for the canine. To complete re-certification, the handler will have to produce the health and vaccinations for the canine. This way, there are no concerns about zoonotic diseases like rabies.

B. **Crisis Response Canine Course**

1. It is the **standard for training deployable canines and handlers.** The National Standards were written in 2010 for civilians. The curriculum is used for many types of organizations, including the FBI and many responder agencies, with slight modifications. However, the National Standards must be met or exceeded.

2. It is a certification and provides 2 million in liability insurance, so it includes behavior assessment, evaluation, refresher training, and re-certification in three years.

C. **CISM/Peer Support/ASIST(suicide prevention)**

1. FEMA and National Crisis Response Canines recognize CISM, so structured group work and one on one best practices using canines are part of the curriculum. The standards mandate crisis intervention training minimum of 6 hours.

i. Self-Care (care of the caregiver training). Resiliency, Struggle Well, etc.

Two hours of training is required per the standards. The nature of the work, as well as the Understanding that the emotional state of the handler travels down the leash to the dog.

D. **K-9 First Aid and CPR**

Due to the nature of disaster response, injuries and overwork are possible. It is a mandate that animal advocacy be part of the curriculum. Every handler that works with canines are required to be able to take care of their partner.

All the above will turn out to be approximately 200 plus hours of training. This is entry-level. Now, the team will need to get experience and develop skills for both the canine and peers. Ongoing training and response are normal and expected in many types of working canines. Police canines do an average of 200 minimum training hours for a single purpose. Maintenance is 16 hours minimum per month per the FDLE for purpose. This is set by USPCA. (United States Police Canine Association). USAR canines routinely do 100 hours of maintenance per year. Ordinance Sniffing canines and Drug sniffing canines all do ongoing training and skill development, which is expected. Liability is a big concern, as is performance. Accidental bites for P.D. canines can be a nightmare, and failure to identify drugs or ordinances can lead to safety and legality issues. The same issues apply to the FFSHC as well. If a canine is not up to dealing with intense environments, they should not be deployed. Aggressiveness has no place on deployment, nor does behavior or health issues that can cause reactivity. There are many reasons to prevent canines from deployment once certified, such as age, medical condition, emotional state of either handler or canine, as well as animal advocacy concerns. It is the responsibility of the handler to deploy with a healthy and mission-ready canine.
An understanding of the different types of canines is helpful in explaining the suggestions.

Types of canines

1. **ESA (Emotional Support Animals)** and **Service Dogs** are dogs trained to serve one person, their handler, who has a mental health diagnosis or physical disability. An ESA is normally a small to a mid-sized, mostly untrained dog and is only allowed for housing and airline travel. Service dogs have ADA public access laws applied to them and are extensively trained. A doctor's note is required for both, and an ESA does not have full public access under Federal ADA law. The terms support dog and comfort dog usually refer to an ESA.

2. **Therapy Dogs** and **Crisis Response Canines** are dogs trained to serve people other than their owners and are appropriate for use in Peer Support. Crisis Response Canines are the standard for deployment in the civilian world currently and are being utilized more and more by organizations as they are trained to deploy. Both have training and certificate or certification standards.

A comparison of Therapy Dog vs. Crisis Response Canines

When we think of therapy dogs, we think of controlled environments like hospitals, schools, and nursing homes. Crisis Response canines are expected to be more resilient to a wider range of human emotions and function in uncontrolled environments at tragedies and emergency scenes. This is why they are the standard for deployment, and the training, curriculum, and prerequisites are more extensive.

Training/Curriculum and Standards

Therapy Dog

The standard training for a Therapy dog is *40 hours of basic obedience training and socialization/acclimation to the expected environment*. They do not have public access laws applied to them but are normally allowed in the organizations that utilize them.

Certification vs. certificate of training: Currently, there are five or so organizations that provide National Registered Certification for Therapy Dogs. They have some important things in common.

1. *Ongoing certification and evaluation.* To re-certify, an evaluation by an industry professional is required as well as written testing on entry and yearly. The registration form for entry into the organization will require knowledge of the canines' training and bite history. Canines with aggression/dominance issues are known liabilities; hence, they will not be accepted as they will not be provided insurance.

2. *Requirements for ongoing yearly visits*. Some have monthly, bi-monthly, or quarterly requirements. This ensures the certified team maintains and can build skills and proficiency.

3. *Liability Insurance* is provided.

4. *National Registry*. Once certification is obtained, they are placed on a national registry, and anyone can look them up.

5. *International Standards.* Animal Assisted Interaction International (AAII) provides standards and best practices for therapy dogs. Some organizations provide training to ensure their teams are functioning up to these standards.

https://otaus.com.au/publicassets/80cfd523-2030-ea11-9403-005056be13b5/AAII-Standards-of-Practice.pdf

While there are many organizations that provide a certificate of training for a therapy dog, they do not include any or all the above. Usually, some basic obedience training or the Canine Good Citizen certificate is required, and that is all.

For these reasons, if a team wants to advance to Crisis Response Canine Certification, it is mandated in the **National Standards for Animal Assisted Crisis Response (AACR)**, National Registered Certified Therapy Dog is required. CISM, ASIST, K-9 First Aid and CPR, and a 2-hour self-care class are also requirements for Crisis Response Certification.

https://www.hopeaacr.org/wp-content/uploads/2010/03/AACRNationalStandards7Mar10.pdf

Crisis Response Canine

The curriculum for AACR consists of the following:

1. Handling skills
2. Canine body language and communication
3. Deployment preparedness
4. Best practices using canines in peer support roles
5. Troubleshooting and behavior issues
6. Self-care for the handler and animal advocacy

Certification includes a $2 million liability insurance coverage, and the certification is good for three years. Re-certification is required and includes ongoing training and evaluation. Training includes practicum scenarios, classroom work, public access, etc. A higher level of socialization and acclimation is required as the canines must be able to work closely with unknown dogs in any environment.
Not every therapy dog can be a crisis response canine, and evaluation includes more behavior assessments.
Minimum training hours are defined in the standards, and any valid AACR program curriculum should reflect that.

All the above suggestions are based on our needs and what is available to us. Eventually, we can do all training without sending our teams to pet therapy dog organizations, as there are many changes in the industry that we should not have to deal with. These organizations are

for civilians who do not have the same concerns of liability and performance that responder agencies do.

First Responder
Mental Wellness Response Subcommittee
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