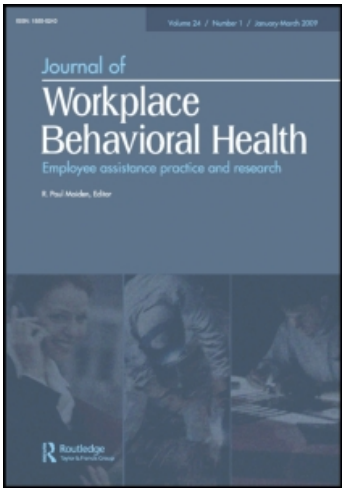

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Occupational and Organizational Issues in Emergency Medical Services Behavioral Health

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Occupational and Organizational Issues in Emergency Medical Services Behavioral Health

Richard Gist
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SUMMARY. Recent advances in research and understanding of the behavioral health impacts of an emergency medical service (EMS) career have necessitated reconceptualization of previous approaches to prevention, mitigation, and intervention. Approaches modeled on critical incident stress debriefing have fallen into disfavor due to a growing body of research indicating little if any efficacy for these techniques while suggesting the potential for paradoxical impacts on the recovery of some recipients. Current recommendations focus on supporting personal and organizational foundations that help to bolster resilience while ensuring that processes are in place to

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provide access to intervention utilizing evidence-informed best practices where indicated.

KEYWORDS. Behavioral health, emergency medical personnel, firefighters, intervention, prevention

INTRODUCTION

There can be little doubt that emergency medical service (EMS) work contains more than its fair share of strain or that certain EMS calls are apt to produce a significant level of stress. This is not a calling well suited for those disposed toward the sedentary or the serene. The emergency side of the enterprise ensures emergency medical technicians (EMTs) a ringside seat, if not a central speaking role, in the greater majority of events listed on the classic Holmes and Rahe (1967) checklist of stressful life events. Even the most routine elements of contemporary EMS work (e.g., routine transfers) can bring providers into repeated contact with demanding people in difficult circumstances.

Whether seen from the health care side or the rescue viewpoint, the EMT will often perceive himself or herself to have been relegated to a rather lowly position in the overall pecking order. When it comes time to pay the bills, there is no escaping the reality of limited pay for long hours. There probably couldn't be a better recipe for disenchantment, especially for providers who studied hard and competed intently for a position in which they could help people and maybe save lives.

But do EMS workers endure radically greater stress than, say, other health care and public safety workers? Are they grossly unsatisfied with their jobs? Are they falling victim to post-traumatic stress disorder (PTSD), suicide, and depression at epidemic levels? Do their careers "burn out" in just 4 or 5 years? Does unrelenting exposure to life's most poignant events lead to intractable harm? Can it be prevented or ameliorated by patent remedies and "self-help" programs? Will the absence of such programs lead organizations to ruin? A quick survey of the industry's folk wisdom certainly leads one to think so (see, e.g., Mitchell, 1983, 1992, 2002). Articles in trade magazines and presentations at trade shows and conferences made sweeping claims about the risk of PTSD while a booming cottage industry arose to offer instruction in how to mount stress management

programs (see Gist & Woodall, 1999, for overview). It all seemed reasonably simple, straightforward, and intuitively clear.

Human responses to life's many challenges are, of course, anything but simple. Those seemingly straightforward questions posed above are actually multidimensional and layered with nuance. EMS workers report more signs of exposure to distressing events than do many others, but this should be expected, given the nature of their work. Just when these reactions should be considered symptoms of dysfunction rather than signs of exposure or symptoms of a preexisting problem presents another, considerably thornier set of questions (Rosen, Spitzer, & McHugh, 2008; Rosen & Lilienfeld, 2008; Summerfield, 2001). EMTs are well aware of the limitations their occupation holds but are also uncommonly attuned to its rewards (Woodall, 1997). To whom should they be compared to determine whether their satisfaction with their careers is greater or lesser than one might normally expect of workers in any other challenging enterprise? Rates claimed for PTSD and depression vary widely between studies, depending on criteria, methods, and assumptions employed (cf. Perrin et al., 2007). Those looking for high rates of disorder seem to find what they are seeking while those looking for resilience find it as well.

The question of whether prescriptive, prophylactic efforts at prevention and intervention can effectively mitigate these impacts is no less complicated. Programs built around "critical incident stress management" (CISM) and its signature intervention, "critical incident stress debriefing" (CISD), permeate the industry and are typically well received as indicators of the organization's concern for the impact of work-related stressors on EMS personnel (Gist, 2002). Despite years of proclamation from promoters and purveyors, though, there is little evidence that these interventions have any appreciable effect on limiting PTSD and a disturbing trend in more extensive studies for debriefing to show paradoxical impacts on natural recovery for at least some recipients (see McNally, Bryant, & Ehlers, 2003, for a definitive overview; see also Lilienfeld, 2007). A number of authoritative guidelines for evidence-based practice in mental health now caution against routine application of debriefing, and some list it as contraindicated (e.g., Australian Centre for Posttraumatic Mental Health, 2007; Gray & Litz, 2005; National Institute for Clinical Excellence [NICE], 2005; Parry, 2001; Ritchie, 2002; Rose, Bisson, Churchill, & Wessely, 2007).

This leaves the EMS manager with a troubling conundrum. It seems evident, on the one hand, that EMS workers have chosen to take on a

challenging occupation and deserve to receive every effort the organization can muster to assist them in coping with its impact. It is also increasingly clear that what has been widely accepted as the industry standard for addressing this concern has proven less than effective and might even become a complication for some persons in at least some situations. Fortunately, a widely growing research base of increasing sophistication seems to offer some useful suggestions.

THERE ARE NO SIMPLE ANSWERS TO COMPLEX QUESTIONS

EMS is a diverse enterprise serving a wide range of constituencies through a vast array of organizational settings and structures. Its providers are as diverse as the communities and patients they serve. It is unreasonable to expect that any more-or-less uniform approach could effectively address the needs of all. Workable approaches must meld a thorough understanding of the organization, its patients and constituencies, the providers who work within it, and the resources available to assist them (Gist & Taylor, 1996; Gist & Woodall, 1999). It is the interactions between these factors, and the interaction of those factors with other aspects of a given provider's life and circumstances, that most determine the impact of any particular encounter. The nature of the call itself, though important, is not generally the element that will distinguish a difficult but manageable encounter from one that proves difficult to shake.

Accordingly, a truly functional behavioral health system has to consider many elements that must be in place and ready to interact prior to any ostensibly precipitating event. The prototypical CISM team was designed as a somewhat labyrinthic structure that operated parallel to the existing organization (see Mitchell & Everly, 1993). Many layers of subprofessional and quasi-professional interventions were cobbled together around a concept that placed the "critical incident" as the centroid. The recommended approaches for today's EMS systems instead combine organizational factors (e.g., management, command, and supervision) known to mitigate the overall impact of the event with highly practical approaches to mitigate its impact on individual providers. Measures designed to permit assessment at appropriate intervals using well-researched but nonintrusive instruments are utilized as indicated to determine who might

require more direct professional intervention. Mechanisms are put in place to refer those in need of professional assistance to providers ready and equipped to deliver well-established and researched, evidence-based treatments. Resources to support providers and their families in dealing with the many problems and issues that complicate daily living, whether or not any specific workplace incident is directly implicated, are also essential features.

The development and interaction of these mechanisms requires that the organization, and especially its human resources components, be thinking and acting strategically as these resources are integrated into worker compensation, employee assistance, and health benefit plans, as well as into operational practices and protocols. Although it can seem a complex maze to navigate, it is actually a matter of building processes that (1) link essential parts of ongoing human resources, operations, and management practices characteristic of any well-managed EMS organization and (2) provide a structure to facilitate their timely and reliable application when indicated.

THE ORGANIZATIONAL COMPONENT: MANAGEMENT, COMMAND, AND SUPERVISION

Experience assisting a wide range of organizations following major disruptive events has led us to appreciate one "bottom-line" axiom: A well-managed, well-run organization will find its way through even the greatest challenges, more or less regardless of what is or is not done to assist. A dysfunctional organization, on the other hand, will struggle intensely from even a much lesser disruption, again more or less regardless of what is or is not done to assist. Put another way, the best predictor of what shape an organization will be in 2 years after an incident of major impact is typically found in what shape it was in 2 days before—the strength of the organization going into the event is the strongest determinant of its strength coming out.

What makes a healthy organization? This is itself a question of such complexity that entire volumes can easily be devoted to parsing that query. For the purposes of this somewhat narrow and necessarily simplified discussion, however, we will focus on the most basic elements of management, command, and supervision.

Management involves how the organization operates with respect to its routine functioning. Emergency operations are certainly a

significant element, but factors such as daily decision making, communication, scheduling, pay and benefits, leave policies, and the like may be even more important. In an elaborate set of studies examining job satisfaction among firefighter EMTs and firefighter paramedics, Beaton and Murphy (1993) found that these matters were by far the dominant issues—exposure to past "critical incidents" was not a significant factor among EMTs and barely achieved significance for paramedics. Employees who are fundamentally dissatisfied with how their workplace affects their lives may blame the organization for the fallout they experience after a difficult occupational event, even to the point of overt recrimination. Employees who feel themselves a strong and committed part of their organization are more likely to focus on how they tackled a difficult challenge and how to improve their response to the next.

Although organizations may differ widely in how they achieve this end, the key to building this sort of commitment is typically found in provider involvement. EMS represents to the consumer the most personal level of service possible. They see a provider coming personally to their aid in their home, their car, or their workplace at a moment of strongly perceived need. That provider speaks to them, listens to them, touches them, and applies skill and concern to mitigating their personal emergency. The quality of the service rendered, from the consumer's viewpoint, is found in the nature of that interaction.

The quality of care, whether viewed from a clinical or a consumer perspective, ultimately depends on the attitude and commitment the individual provider brings to the encounter. The organization that gives its providers a strong voice and reflects that voice in how it operates stands to benefit in many ways. Where employees are represented by labor organizations, labor/management partnerships in all aspects of the organization have consistently shown value. Among the more subtle but potentially most significant benefits is the foundation such involvement provides when EMS organizations and their employees must confront challenging occupational events.

Command refers to how the organization structures its execution of emergency responses. Although management often functions best as a circle, command is unquestionably a pyramid. The most effective emergency response organizations are those that move seamlessly from circles to pyramids and back again to circles. Those organizations plan their response patterns in an inclusive fashion, with active input from all levels. They execute those protocols with structured

efficiency, using practiced incident management systems (IMS). When the incident is over, whether a routine call or a complex event, they systematically evaluate their performance and refine their protocols with the same range of input and participation that characterized their planning. The evolution of a national standard for structured incident management (Federal Emergency Management Agency [FEMA], 2007) has provided the rescue disciplines with an outstanding tool that greatly facilitates this important capacity.

Another observation learned through assisting a wide range of agencies following major events is that those without a practiced and effectively implemented incident management structure struggle mightily to piece the event together and wrestle through its implications whereas those with a solidly executed incident management system tick through the experience with practiced efficiency, coming to reasonably smooth focus on strengths, weaknesses, and implications. The lesson has been painfully clear in many events, large and small: If you want to control incident stress, you must begin by controlling stressful incidents.

Consistent application of IMS, even and especially in routine encounters, is a critical key in successful execution. Successful execution is a major factor in personal and organizational resolution. Coupling this to a consistent and effective system of after-action review, again to even and especially include the routine as well as the atypical event, provides a sound basis for processing the experience and learning from its implications.

Supervision is all too often the weak link in the organizational triad. This is not usually due to inability or unwillingness of supervisors to perform their roles. It is more typically due to a lack of definition and preparation respecting that role at the organizational level. It is the first-line supervisor who turns ideas into actions, policies into practices, and operations into outcomes. The character of the organization is ultimately determined by how the first-line supervisor carries the values of the agency to the providers who touch the patients. Unfortunately, there has generally been less preparation, less development, less direction, and less support for this critical role than for any above or below. There are courses and classes for executive leadership, and entire certificate and degree programs are devoted to preparing direct service providers. Offerings for first-line supervisors, however, are too often scarce and limited.

There's an old organizational adage that certain things flow downhill. If that's the case, it might be fair to say that the first-line supervisor

lives on the flood plain. Because the effectiveness of the service delivered depends on the attitude and performance of the providers, the supervisor has to nurture their compliance and commitment while satisfying the imperatives of the organization and its management. Such a role demands skill, diplomacy, courage, and aplomb—"people skills," if you will—in at least equal measure to the clinical and technical skills required of one who must monitor, instruct, advise, and correct as a matter of course. It can easily be the most demanding and most stressful role in the organization. It can also be the most critical in dealing with stressful occupational events.

Traditional CISM approaches were based on self-proclaimed experts telling providers what they purportedly needed and how it should be packaged. Halpern et al. (2006; also detailed in Halpern, personal communication, January 13, 2008), took a much different but eminently more reasonable approach by instead asking Canadian EMS providers what types of assistance they felt to be useful and how they would want that assistance to be delivered. Paramedics, supervisors, and dispatchers were questioned in detail about their strategies for coping and their ideas for enhancing recovery. These weren't just questions idly tossed out in conversation but were part of a coordinated study to find better ways to support EMS workers in the field.

Systematic interviews were conducted in groups and individual sessions where the responses were transcribed, coded, and analyzed for common themes. Most of the providers' suggestions concentrated on very practical workplace steps, such as a half-hour to 1 hour "time-out" period to recoup and regroup (alone or with coworkers of their choosing, at their option), coupled to expression of support and interest from supervisors. Providers who indicated they might like more specific or detailed discussions said they would choose to do so at their own pace and in their own contexts in the days and weeks after the event.

Even though traditional CISM interventions have failed to live up to their sweeping promises to prevent PTSD, they are generally well received as expressions of organizational support (Gist & Woodall, 1999). Such expressions are indeed important, and it is only reasonable that some clear and cogent set of supportive responses should continue to be made following distressing events in the field. But the repeatedly demonstrated lack of preventive efficacy and the apparent potential for paradoxical impacts in at least some recipients of traditional CISD render it prudent to look at other ways to provide that responsiveness. The approach suggested by the participants in Halpern's study can be

TABLE 1. Core Elements of Psychological First Aid

Contact and engagement
Safety and comfort
Stabilization (if needed)
Information gathering: Current needs and concerns
Practical assistance
Connection with social supports
Information on coping
Linkage with collaborative services}

Source: After Brymer et al., 2006; complete manual available at http://www.ncptsd.va.gov/ncmain/ncdocs/manuals/PFA_2ndEditionwithappendices.pdf.

easily adapted to most EMS systems and represents a reasonable ''first-step'' response that will accommodate most situations while also providing a foundation for approaching more complex situations. If tempered with a working understanding and application of the basic principles of psychological first aid (Brymer et al., 2006; see Table 1), it can easily reflect the current standard for evidence-informed best practices while remaining organizationally integrated, psychologically nonintrusive, and operationally flexible.

This strategy can also allow the organization to reserve more clinically flavored interventions to be delivered specifically to those who clearly need them by professional clinicians fully prepared to deliver them. Those decisions should be based on well validated assessment tools and result in referral to fully qualified professionals prepared to deliver evidence-based interventions in the context of an established clinical relationship. To achieve the best utility, accessibility, and utilization, professional interventions should be integrally linked to a comprehensive employee assistance program (EAP) provided to address the behavioral health needs of providers and their families in all aspects of healthy living. The EAP, in turn, should be embedded in a defined and comprehensive program to enhance and maintain the overall health, wellness, and fitness of EMS providers.

THE PROFESSIONAL MENTAL HEALTH COMPONENT: EAPS AND SPECIALTY PROVIDERS

The industry has reasonably clear standards for how an ambulance should be built and what it should carry. There are well-established

standards for personal protective equipment and safety devices. What will be done to treat patients is generally well specified in protocols and closely reviewed in quality assurance measures. What will be offered to providers for behavioral health care and how it will be delivered is surprisingly circumspect in comparison.

NFPA 1500 (National Fire Protection Association [NFPA], 2007), the health and safety standard for fire service agencies, mandates that all agencies provide a member assistance program (essentially an EAP named to more inclusively reflect the standard's applicability volunteer as well as career agencies). Although intended to ensure that all providers have access to behavioral health assistance and that this resource will extend beyond programs aimed at incident-related stress, there is no delineation of what services should be provided by what level of clinician, or of what standards should guide the choice of treatments or provide the benchmarks for adequate outcomes. Although there is a rich history surrounding EAP services, there is unfortunately little in the way of rigorous research or evidence-based industry standards to guide the EMS agency seeking an assistance plan for its members. Too often, services provided have been driven more by what the EAP provider offers for sale than what the consumer needs or requires.

Traditional CISM programs seemed initially to have filled this void with respect to incident-engendered distress. They prescribed very specific intervention rubrics and advocated protocols for utilization, often making attendance mandatory. These were predicated on claims of definitive scientific evidence for efficacy and effectiveness (see, e.g., Mitchell, 1992). Unfortunately, independent research has demonstrated these claims to have been seriously overstated and has called the interventions and the constructs on which they were based into serious question (cf. Devilly et al., 2006; Gist, Woodall, & Magenheimer, 1999). What remains for the EMS manager is a difficult conundrum in which he or she must somehow evaluate very technical levels of information to decide what is best to provide for his or her employees. This can become even more complicated, since ordinary sources of guidance have typically presented—and may sometimes still present—information and recommendations that now conflict with current evidence informed best practices.

It is common for a drug or procedure that seemed promising in early trials to be discarded or recalled when independently conducted controlled studies find its efficacy limited or its risks to outweigh its demonstrable benefits. It is also common for those who hold vested

interests in the product or procedure to dispute research that places their investment in peril and argue to keep their products in the marketplace. The difference lies in the standards used to determine safety and efficacy, and in the presence of independent regulatory bodies with authority and responsibility to enforce those standards. There is no Food and Drug Administration (FDA) regulation of these workplace interventions (or of behavioral health interventions in general). The only operating standard is caveat emptor: "Let the buyer beware" (Devilly & Cotton, 2004; Lilienfeld, 2007).

Given the absence of credible evidence in the refereed literature of medicine and psychology that standard CISM interventions provide clinical benefits and repeated suggestion that they may complicate recovery for at least some recipients, there has been suggestion in several quarters that the tide may have shifted to present actual liability on the part of the providers of such interventions (Devilly & Cotton, 2004) and EMS agencies that sponsor, much less mandate, participation (Bledsoe, 2003). It is incumbent on EMS managers, then, to acquaint themselves with current best practices according to what authoritative standards exist (see, e,g,, the guidelines of the Oxford-based *Cochrane Collaboration* regarding debriefing following trauma; Rose et al., 2007; see also the guidelines of the United Kingdom's National Institute for Clinical Excellence, NICE, 2005; those of the Australian Centre for Posttraumatic Mental Health, 2007; and the recommendations of the National Institute of Mental Health/Department of Defense consensus panel on early interventions following terrorism, Ritchie et al., 2002; see as well Devilly, Gist, & Cotton, 2006; Gist, 2002; Gray & Litz, 2005; McNally, Bryant & Ehler, 2003). A basic outline of current recommendations is summarized below:

1. Immediate assistance should be proximal, nonintrusive, and ecologically intact, utilizing principles of psychological first aid (Brymer et al., 2006) as indicated by the situation and circumstances. The mechanisms discussed above regarding organizational and supervisory responses can be shaped to fill this need in most circumstances. When extraordinary events require more focused support, the element of greatest comfort and utility is often found in visits from "upward contacts" (cf. Taylor & Lobel, 1989; see also Gist & Taylor, 1996; Gist & Woodall, 1995), to wit, peer-level representatives of agencies seen as having experienced and mastered similar challenges. These are much better conceived as informal

supportive visits than as interventions with a formal preventive intent—more in tune with what you learned from grandma than what you studied in grad school. They provide much-needed solace and solidarity and can help people feel more comfortable reaching out for further assistance if and when needed. Although unquestionably comforting and often critical to moving ahead, they can often accomplish these vital ends even better when not treated as if an element of formal intervention.

2. Early, reliable, and nonintrusive assessment should be seen as an essential element in the process of resolution. Although most EMS providers experience some level of distress following difficult duty, the greatest majority will not see that distress rise to levels that demand clinical treatment. Indeed, most persons respond to even deeply unsettling experiences with resilience rather than requiring recovery (Bonanno, 2004), and it is not really possible to reliably distinguish in the immediate aftermath who will rebound from who will need extra assistance to regain equilibrium. The best approach in the early stages is generally one of practical support, compassion, and watchful waiting, referring any providers displaying obvious or profound difficulties for professional behavioral health intervention as indicated by their level of impairment.

   Brewin et al. (2002) reported on the development of the *Trauma Screening Questionnaire* (TSQ), a simple, straightforward, and nonintrusive short questionnaire that has demonstrated very good utility in identifying those for whom resolution is progressing well and suggesting who may require fuller assessment for clinical treatment of PTSD. Consisting of 10 simple queries with "yes" or "no" responses regarding whether the indicated symptom has been experienced more than twice in the preceding week (see Table 2), it can be scored by rote counting of positive responses using a threshold of 6 or more affirmative replies. It can accordingly be used with outstanding efficiency in primary care settings, workplace screening, and even as a self-assessment tool. Its capacity in various trials to screen out cases that will not experience clinical levels of impairment has been quite strong, and its capacity to identify those who will require further intervention as been reasonably acceptable for a screening instrument.
3. Stepped care entails providing treatment specifically to those who need it at levels that match their clinical needs. Although

TABLE 2. Trauma Screening Questionnaire

	Yes, at Least Twice in the Past Week	No
1. Upsetting thoughts or memories about the event that have come into your mind against your will		
2. Upsetting dreams about the event		
3. Acting or feeling as though the event were happening again		
4. Feeling upset by reminders of the event		
5. Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event		
6. Difficulty falling or staying asleep		
7. Irritability or outbursts of anger		
8. Difficulty concentrating		
9. Heightened awareness of potential dangers to yourself and others		
10. Being jumpy or being startled at something unexpected		

Source: Brewin et al., 2002.

basic palliative support is generally appreciated by most who have experienced distressing events, it may not be of universal benefit and can feasibly prove detrimental to some. Indeed, several studies of cardiac patients following major coronary events have found that a significant minority actually do better if not enrolled in seemingly benign interventions such as psycho-educational support and symptom education (see, e.g., Frasure-Smith et al., 2003; Ginzberg, Solomon, & Bliech, 2002). Studies of early interventions based on debriefing techniques have also shown these sorts of paradoxical impacts (cf. Bisson et al., 1997; Mayou et al., 2000).

In cardiac patients, these exceptions were related to persons who normally employed repressive coping mechanisms. These patients fared as well or better than others if left to their own devices but deteriorated when involved in ostensibly supportive interventions that challenged their normal patterns of coping. Given that it has often been claimed that EMTs and firefighters need prophylactic intervention because they tend to utilize repressive coping (cf. Mitchell, 1983 *et seq.*), and given that those who

appear to cope repressively have often been among those targeted for and compelled to attend debriefings and similar interventions, it is evident that more specificity and flexibility in our approaches is clearly indicated.

Although many experienced EMS providers are well acquainted with the transient discomfort that recollections of particularly poignant occupational experiences often bring, most have developed methods of regulating their discomfort that ordinarily work to keep it from interfering with their lives and careers (Gist & Woodall, 1999). Where transient but subsyndromic discomfort proves recalcitrant or troublesome, referral to EAP providers or established self-help resources can be helpful in shoring symptom management skills and in addressing external stressors that may be compounding the provider's ordinary capacity for self regulation (see Litz, Engel, Bryant, & Papa, 2007, for pilot study of an online self-management program). Where symptom manifestation reaches clinical thresholds, referral to specialty providers for evidence based treatment of the clinical conditions manifested is warranted.

4. Evidence-based treatment of clinical conditions by competent and credentialed specialty providers should be considered the standard of care for cases that reach diagnostic thresholds. Just as we fully expect to refer orthopedic injuries to competent surgical specialists or occupationally engendered infections to appropriate specialists in infectious diseases, we should be prepared to refer cases of psychiatric syndromes associated with occupational exposures to the care of carefully selected specialists employing evidence-based treatments consistent with current authoritative guidelines for appropriate intervention. This can be especially confusing in the realm of psychological trauma, where (as noted above) there is little objective regulation upon which to rely for guidance and where "fringe therapies" that offer sweeping claims but little objective evidence abound (see Gist et al., 1999, or Lohr, Hooke, Gist, & Tolin, 2002, for overviews). The treatment guidelines noted earlier converge on the well-documented efficacy of trauma focused variants of cognitive behavior therapy (CBT) utilizing graded exposure (see also Institute of Medicine, 2007, for detailed overview of evidence regarding clinical treatment of PTSD). This approach has demonstrated efficacy in a range of applications, including treatment of PTSD

in World Trade Center survivors (Levitt et al., 2007). On the other hand, many treatments typically employed in routine therapy have been found to be relatively ineffective in treating conditions such as PTSD.

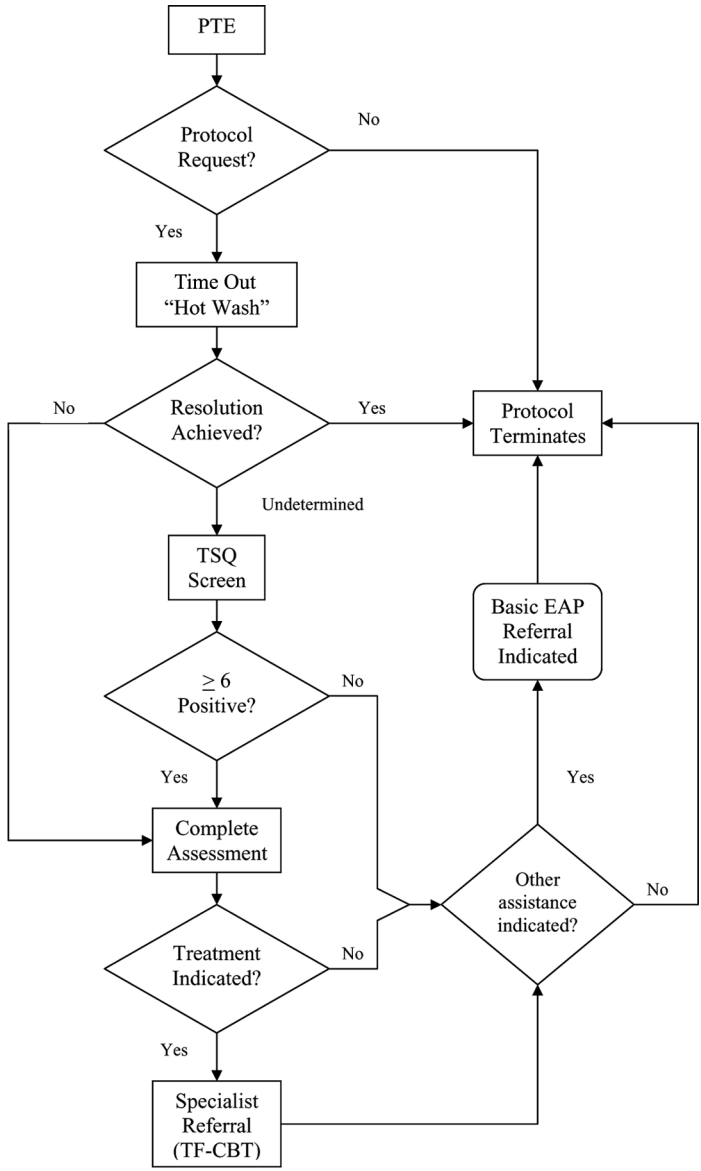
It is important to verify that the specialty clinician to whom referral is made is competent to provide this level of care. When unacquainted with a field, managers typically look to certifications and credentials. Not all are created equal. "Vanity" certifications (e.g., "Board Certified Expert in Traumatic Stress" [BCETS] from the American Academy of Experts in Traumatic Stress or "Certified Trauma Specialist" [CTS] from the Association of Traumatic Stress Specialists) abound in the field of psychological trauma, providing certification for a fee based on self-documentation of training and experience. Definitions of acceptable credentials are often so broad that anyone from chiropractors to sociologists can qualify, severely limiting the credence a manager can place in the certification bestowed. Since recognized professional bodies such as the International Society for Traumatic Stress Studies and professional boards associated with the major disciplines do not provide such specialty certification, EMS organizations must investigate training and preparation of potential specialists in greater depth than required for a board-certified medical specialist such as a surgeon or internist. Documented training and supervised experience in critical techniques such as CBT should be considered imperative.

BUILDING A BASIC PROTOCOL

Figure 1 provides a flow chart for a basic protocol addressing potentially traumatic events (PTEs) derived from elements outlined above. It is not intended as a prescription but is rather a basic schematic to be adapted to the needs, structure, and pragmatics of any given organization. It is built to accommodate stressful impacts of more basic EMS encounters with full expectation that it will be treated flexibly and adapted as required for more complex incidents.

1. *Experience of a PTE.* One provider's trauma may well be another's routine experience. The reaction is on many levels a subjective one, driven by the individual EMS provider's experiences, sensibilities,

FIGURE 1. PTE Protocol Flow Chart



Note: PTE = potentially traumatic event; TSQ = Trauma Screening Questionnaire; EAP = employee assistance program; TF-CBT = trauma focused-cognitive behavioral therapy.

and personal situations. Accordingly, the first question is "Does the provider consider it significant?" If so, he or she can request initiation of the protocol; if not, an expression of concern and the availability of help if needed may be all that is required.

2. *Time out "hot wash"*. The "hot wash" is an element of the military after action review (AAR) process that, especially if flavored as indicated with principles of psychological first aid, can make the "time-out" advocated by Halpern et al. (2006) useful, helpful, and nonintrusive. Its basic structure is simple: What happened? What was successful? What could have gone better? How might we improve? Who should we tell about what we've learned? If that appears sufficient, the process may be complete; if serious issues are obvious, referral for assessment is prudent. If it still seems unsettled, a quick and non-intrusive screening such as the TSQ (Brewin et al., 2002) may be employed at 3–4 weeks.
3. *TSQ screening*. As noted above, the TSQ is simple, straightforward, and easily scored. If fewer than six items are endorsed, resolution can generally be expected. If six or more items receive positive responses, referral for a more complete assessment is indicated. Should a given provider screen as subsyndromic but still need assistance with symptom regulation or compounding life issues, appropriate referral for basic EAP assistance should be considered
4. *Complete assessment*. This can typically be accomplished by a qualified EAP provider using appropriately validated instruments and procedures. Specialty treatment may not be indicated, but the EAP can help with symptom management or external stressors that are complicating the provider's usual capacity to deal with the circumstance. Where clinical treatment is indicated, referral should be made to a competent specialist fully qualified in appropriate evidence-based techniques.
5. *Treatment by specialty clinician*. This should be a specialist (typically a board-certified psychiatrist; a licensed, doctoral-level psychologist; or a certified clinical social worker) with advanced training and supervised experience in specific, evidence-based treatment models supported by current clinical guidelines (e.g., CBT for PTSD, anxiety disorders, and depression). Occupationally related PTSD has typically responded to relatively short treatment cycles (12–25 sessions in the Levitt et al., 2007, study) but is often accompanied by other issues that may benefit from further

EAP assistance (e.g., family impacts). Accordingly, evaluation for other needed or desired assistance completes the protocol.

THE FINAL FUNDAMENTAL: PERSONAL WELLNESS AND FITNESS

Resilience is ultimately determined more by the providers' capacity to absorb stressful exposures on the job than by either the nature of the exposures themselves or the responses to exposures after the fact. This requires a fundamental commitment from the provider to his or her own health, wellness, and fitness, and a fundamental commitment from the agency to provide resources and support for maintaining those capacities in its members. Although the nature and design of comprehensive wellness and fitness programs is beyond the scope of this article, it is important to emphasize their critical role in promoting the resilience of EMS providers. The International Association of Firefighters and the International Association of Fire Chiefs have developed a *Joint Labor Management Wellness and Fitness Initiative* (1997) that provides an excellent overview of the critical elements of effective programs for career agencies, whereas the National Volunteer Fire Council and the United States Fire Administration (2004) published a similar initiative for volunteer organizations.

A strong and effective EAP, with organizational encouragement to make confidential and proactive voluntary use of its services for any personal, family, or life problems regardless of their genesis, is an essential element of any comprehensive wellness and fitness program. At a minimum, such a program should be able to offer assistance with marital and family problems, substance abuse, and basic counseling needs, with capacity to assist or refer for matters such as legal or financial problems. No program intended to support behavioral wellness can be considered truly complete unless imbedded in a comprehensive program of health, wellness, and fitness that includes an effective EAP.

CONCLUSIONS

EMS is a career that demands a great deal from its providers but also provides strong intrinsic rewards. Sound organizations

realize these demands and build processes that promote personal and organizational resilience while providing access to intervention systems employing evidence-based best practices for providers who may require professional assistance following difficult occupational events.

Contemporary best practices have shifted significantly based on evolving research. Traditional CISM approaches were adopted in an attempt to meet an important need but must be reconsidered and reconceptualized to reflect current understandings, advances in strategies and techniques, and emerging standards for evidence-based behavioral health care. Processes to provide organizational support and access to professional care as needed are suggested as frameworks from which organizationally specific models can be constructed to fit the needs of particular EMS agencies.

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