Workgroup Summary

Mental Health and Wellbeing

Overarching Goal:

Provide comprehensive mental health and wellbeing resources, including those focused on suicide prevention, for all Fire and EMS personnel.

Issue:

Fire and Emergency Service (EMS) personnel[14] are exposed to events that have powerful and lasting impacts on their mental health and wellbeing. Challenges include cumulative exposure to structural fires, mass casualty events, natural disasters, medical emergencies, suicide, pediatric calls, violence, and others. Fire and EMS personnel also cope with organizational dysfunction, internal moral injury, Line-of-Duty Death (LODD), and the profound biopsychosocial impact of shiftwork[15] and sleep deprivation. Volunteer Fire and EMS personnel may encounter the additional stress of managing work-life-volunteer balance. Mounting evidence reflects that Fire and EMS personnel are at increased risk for a range of mental health challenges and disorders.

Historically, mental health and wellbeing support, as part of an overall healthy lifestyle, has not been well integrated into fire service culture. Fire/EMS personnel may often face barriers to care due to mental health provider shortages throughout the United States. Even when available, mental health clinicians often lack specialized professional training to deliver culturally effective care when treating clients in public safety occupations. This lack of cultural awareness in working with Fire/EMS personnel can have a compounding negative effect and further compromise engagement in seeking mental health care.

Although important strides have been made to normalize the topic of mental health in the fire service, greater attention and resources are needed, as cultural stigma continues to be a persistent impediment to comprehensive progress. In addition, significant disparities exist in the utilization of available mental health programming and resources, which are often influenced by age and years of service. To date, there is no formal national strategy for monitoring rates and predictors of occupational stress injuries and/ or suicide within the fire service. While significant efforts have been made in 2024 to better understand the impact of state-level policies that target firefighter mental health and wellness,[16] continued rigorous assessment and subsequent evaluation of programming is needed.

Firefighters and other rescue personnel develop post-traumatic stress disorder (PTSD) at a rate similar to military service members returning from combat, according to an August 2016 study from the Journal of Occupational Health Psychology.[17] This report reveals approximately 20% of firefighters and paramedics may meet the criteria for PTSD at some point during their careers, compared to a 6.8% lifetime risk for the general population. In addition, according to the National Vital Statistics System (NVSS), the rate of male firefighter suicide in the United States is 33.8 per 100 people, compared to 17.8 per 100 people among all working-age adults ages 18-64.[18] Policy and programming efforts aimed to reduce firefighter suicide should incorporate defined goals established in the National Strategy for Suicide Prevention released in April 2024.[19] Efforts in this report that align with federal strategic directions on suicide prevention include integration of suicide prevention into workplace culture, improved access to crisis care, and, among other needs, prioritization of quality research of firefighter suicide and suicide prevention.

This report underscores the complex mental health issues that Fire and EMS personnel experience and highlights the need for a federal, state, and local inter-disciplinary, cross-organizational series of strategies to reduce the debilitating effects of cumulative occupational stress and exposure, including:

1. Culturally informed mental health specialists to address the unique needs of Fire and EMS personnel.
2. Ongoing research to develop mitigation strategies to manage the impact of repeated traumatic exposures.
3. Financial support for mental health services.
4. Compilation of best practices for building and promoting a supportive culture for normalizing help-seeking behavior.
5. Gathering best practices for obtaining access to mental health and wellbeing resources.
6. Identification of measurable outcomes and valid tools to assess progress toward the overarching goal.

A national research agenda for first responder mental health is required to advance all strategic areas outlined in this report: Culture, Providers, Individual Values, Interventions, Predictors, and Funding.

Accomplishments:

- Adoption of interstate licensing compacts for licensed mental health professionals has progressed rapidly in 2023-2024. To date, a combined forty-two states and Washington, DC have enacted interstate compact legislation through the Psychology Interjurisdictional Compact (PSYPACT), the Counseling Compact, and/ or the Social Work Licensure Compact. Historic progress in the enactment of interstate licensing compacts has paved the way for mental health clinicians from a range of professional disciplines to practice across state lines, expanding provider access and choice for first responders seeing mental health services as consumers. (See Appendix A)
- The Mental Health and Wellbeing Workgroup has developed a guide on recommended mental health clinician standards, which outlines specific clinician criteria for providing trauma-informed, highly skilled, and culturally aware care to fire service members. (See Appendix B, "Core Characteristics for Mental Health Clinicians Working with Fire and Rescue Personnel".)
- Efforts continue across the fire service to increase access to and catalog vetted mental health clinicians, who demonstrate cultural awareness, advanced training, and/ or special experience working with fire service populations. The National Volunteer Fire Council's (NVFC) Behavioral Health Directory was recently established and is intended to categorize vetted clinicians by zip code, state, specialty, and insurance accepted. A similar directory of mental health providers who self-identify as working with first responders has also been established by Responder Strong, a partner of the non-profit organization NDRI Ventures.
- The Workgroup has identified at least eight training programs (below) designed to prepare mental health clinicians to treat Fire and EMS personnel. In conjunction with efforts to develop recommended core curriculum guidelines for clinician training, **these programs require further evaluation, comprehensive vetting and classification by the next cohort of the USFA Mental Health and Wellbeing Workgroup**.
  1. Understanding the Fire Service for Mental Health Clinicians hosted by International Association of Fire Fighters (IAFF)
  2. Treating Fire Service Members in Behavioral Health Settings hosted by International Association of Fire Fighters (IAFF)
  3. Clinician Awareness Program hosted by the Florida Firefighters Safety & Health Collaborative and UCF Restores
  4. Understanding Fire Service Culture / Fire Service Cultural Competency Certificate Program hosted by the Fire Service Psychology Association (FSPA)
  5. Helping Heroes hosted Medical University of South Carolina
  6. A Firefighter's Life, hosted by Firefighter Behavioral Health Alliance (FBHA)

7. Certified First Responder Counselor hosted by Lighthouse for Public Safety/ Academy Hour
8. Occupational Awareness Training hosted by First Responder Health (Canada)

- The Workgroup has identified three gold standard resources that offer a fundamental framework for comprehensive mental health and wellness programming that can be adopted by career, volunteer, and combination fire departments (IAFF/IAFC Wellness Fitness Initiative, First Responder Behavioral Health Access Program (BHAP) Toolkit, and NVFC Psychologically Healthy Fire Departments: Implementation Toolkit).
- The Workgroup has identified 19 topics of interest to contribute to a national research agenda that deepens understanding of first responder mental health.
- The Workgroup has identified six evidence-based prevention programs that promote individual psychological resiliency and/ or suicide prevention in the fire service.

Recommendations:

Overall

The United States Fire Administration (USFA) shall be provided the legislative mandate to create an Advisory Panel on Mental Health and Wellbeing of the Fire Service. The Advisory Panel shall assume responsibility for the following functions undertaken by the 2024 Mental Health and Wellbeing Workgroup:

1. Organize sub-advisory groups to include content experts to aid in the development of the recommendations.
2. Provide oversight to sub-advisory groups.
3. Provide comments and recommendations to the Fire Administrator regarding necessary resources to address the identified needs.
4. Provide improvements and/or revisions to recommendations deemed appropriate.
5. Review scientific research in the areas of mental health and wellbeing.

The following are immediate actionable steps identified by the Workgroup for the United States Fire Administrator to consider:

1. Contact counterparts at federal agencies (DHS, CDC, HHS, NIOSH, DOJ, DOD, NIH/ NIMH) to establish a working group focused on information sharing on first responder mental health initiatives.
2. Request a meeting with the Centers for Disease Control (CDC) Director to discuss strategies to prioritize first responder mental health research, prevention, and treatment strategies.
3. Convene national health care entities to prioritize access to culturally competent care for first responders.
4. Continue discussion with the Substance Abuse and Mental Health Services Administration (SAMHSA) Director to explore the adoption of adding a dedicated first responder option to the 988 Suicide and Crisis Lifeline.
5. Engage the National Fire Protection Association (NFPA) on its next Fire Service Needs Assessment Survey; plan measurable data points to illuminate successful programs and unmet needs.
6. Call on the First Responder Center for Excellence (a division of the National Fallen Firefighters Foundation) to re-establish the annual Mental Health Symposium in 2025 to highlight best practices, successful programs, and creative implementation strategies.
7. Establish full-time staff in the USFA Division of Research, charged with executing Workgroup report action steps.

8. Execute the Federal Advisory Committee Act (FACA) process to establish a federal advisory group to prioritize envisioned work.

Culture

Convene a sub-advisory panel charged to:

1. Identify existing and/or build new resources for department personnel of all ranks, to integrate into mental health and wellbeing culture initiatives.

The Workgroup has identified the following key resources in this area:

   a. The Wellness-Fitness Initiative 4thEdition developed by the International Association of Fire Fighters (IAFF) and the International Association of Fire Chiefs (IAFC), outlines a comprehensive behavioral health program model for organizations to support the mental and behavioral health needs of recruits, active fire fighters, and retirees.

   b. The First Responder Behavioral Health Access Program (BHAP) Toolkit (established by the Second Alarm Project) is a free comprehensive resource designed to support the behavioral health needs of fire and emergency services personnel, offering a range of evidence-informed strategies and interventions and resources for an organization to establish and customize or enhance an existing behavioral health program.

   c. The Psychologically Healthy Fire Departments: Implementation Toolkit (developed by the National Volunteer Fire Council) is designed to foster member wellbeing while enhancing department performance. Although there is no "one-size-fits-all" approach to creating a psychologically healthy fire department, the types of practices that support wellbeing and performance can be grouped into six categories: Member Involvement, Health and Safety, Member Growth and Development, Work-Life Balance, Member Recognition, and Effective Communication.

Additional resources that promote the integration of mental health and wellbeing into organizational culture include:

   a. Mental Health Awareness Month Toolkit | SAMHSA

   b. Workplace Mental Health - The Working Well Toolkit

   c. San Bernardino, California Behavioral Health Toolkit

   d. Center for Firefighter Behavioral Health – Medical University of South Carolina

2. Establish a national research agenda that promotes a deeper understanding of first responder mental health. A non-exhaustive list of existing research initiatives that would benefit from additional federal support and/ or reflect current research gaps in first responder mental health that warrant further attention are indicated below.[20] (Note: the Workgroup chose not to create a prioritized list, but rather ordered the list with a focus on magnitude):

   a. Assessment of integration and implementation of existing mental health resources into fire service organizations.

   b. The development of supportive cultures for seeking mental health and wellbeing resources throughout the life cycle of a first responder.

   c. Development of large-scale, long-term cohort studies to identify predictors of suicidal ideation, depression, anxiety, and substance use/abuse disorders among Fire/EMS personnel

   d. Assessment of the impact of incorporating changes to ICD 10-Z codes to include the occupational stressors of Fire/EMS personnel.

   e. Analysis of data collected by the Public Safety Office Suicide Reporting Module of the National Violent Death Reporting System (NVDRS), to be released by the CDC in 2024.

f. Identification of protective and predictive factors in post-service (retiree) first responder mental health.

g. Evaluation of post-critical incident downtime for Fire and EMS personnel.

h. Efficacy of peer support intervention in countering short-term and long-term effects of traumatic occupational exposure.

i. Utilization and efficacy of first responder mental health and wellness mobile apps.

j. Evaluation of mental health, productivity, and social wellbeing outcomes of afternoon or evening shift start times.

k. Utilization and efficacy of therapy dogs in mitigating acute effects of traumatic occupational exposure.

l. Evaluation of longitudinal outcomes on fire service members who attend residential or inpatient behavioral health treatment.

m. Exploration of best practices in aftercare for fire service members to maintain treatment gains (i.e. symptom stabilization, quality of life improvements) achieved in intensive, partial, or inpatient levels of behavioral healthcare.

n. Evaluation of treatment efficacy of existing PTSD psychotherapeutic interventions for fire service cohorts (see list under *Interventions*, recommendation #1).

o. Analysis of safety and efficacy of emerging interventions (ex: Stellate Ganglion Block (SGB), psychedelic-assisted therapy, acupuncture) as alternative or integrative treatment interventions for PTSD.

p. Analysis of return-on-investment (ROI) utilizing health economist perspective on mental health and wellness programming in the fire service.

q. Identification of best practices for retirement planning and post-retirement mental health support for first responder populations.

r. Identification of best practice strategies to maintain mental health and wellness among fire service leaders.

s. Meta analysis on efficacy of stress inoculation and resiliency programs through the fire service.

Individual Values

Convene a sub-advisory panel charged to:

1. Develop and sustain a comprehensive, evidence-based, industry-focused marketing campaign to normalize mental health and wellbeing support as one component of an overall health and wellbeing lifestyle.
2. Identify drivers and barriers to seeking mental health and wellbeing support to reveal future research opportunities.
3. Evaluate patterns of use of existing mental health resources across age and length-of-service cohorts within the Fire/EMS community and, if indicated, develop strategies to improve utilization tailored to unique groups.
4. Develop policy templates for departments to implement immediate and on-going assistance to Fire/EMS personnel who are seeking mental health and wellbeing support. Templates are needed to support members coping with both occupational stress due to traumatic exposure to critical or high-risk incidents, as well as those coping with non-occupational personal or environmental life stressors.

Providers

Convene an ongoing sub-advisory panel of stakeholders charged to:

1. Support interstate licensing compacts for mental health treatment providers in all 50 states and territories.
    a. In remaining states without enacted legislation, fire service and public safety leaders are encouraged to work with state legislatures to adopt permissive legislation. This may include connecting advocates in states without legislation and mentors in states with legislation to facilitate passage.
2. Develop and disseminate evidence-based standards for defining a trauma-informed, culturally-competent clinician.
3. Provide clinician training programs to enhance efficacy and treatment delivery for mental health clinicians interested in working with Fire/EMS personnel. Include standards for number of hours of ride-along time with Firefighters, EMT's, and Paramedics to be considered culturally-competent and trauma-informed.

Convene a sub-advisory panel charged to:

1. Prepare educational materials for Fire/EMS personnel to understand what mental health and wellbeing therapy is, how to access it, what to expect, the different types of therapies, the professional qualifications and skills of provider types, differences between experimental and certified best-practice approaches, and what to look for when seeking support.
2. Identify and utilize funding sources for development of education materials.
3. Identify and provide information about existing programs (i.e., 988) to support individuals in crisis as well as report those in need.
4. Identify one source to host, publish and maintain the materials.
5. Advance a national communication and dissemination strategy for all the mental health and wellbeing materials.

Interventions

Convene a sub-advisory panel charged to:

1. Identify available evidence-informed, mental health and wellbeing interventions, as well as those needing validation addressing prevention, intervention, and post-intervention programs or strategies. The Workgroup identified 10+ evidence-based mental health treatments or interventions that are recommended to address common mental health challenges that impact Fire and EMS personnel. This is not an exhaustive list but includes (without prioritization):
    a. Cognitive Behavioral Therapy (CBT)
    b. Cognitive Processing Therapy (CPT)
    c. Dialectical Behavioral Therapy (DBT)
    d. Exposure Therapy (PE)
    e. Accelerated Resolution Therapy (ART)
    f. Eye Movement and Desensitization Reprocessing Therapy (EMDR)
    g. Motivational Interviewing (MI)
    h. Brief Strategic Family Therapy (BSFT)
    i. Suicide Postvention
    j. Nutrition-based intervention[21]

2. The Workgroup identified the following examples of evidence-informed prevention programs that promote individual psychological resiliency and/ or suicide prevention in the fire service. This is not an exhaustive list but includes (without prioritization):
    a. IAFF Safety Planning Intervention for Suicide Prevention
    b. IAFF Resiliency Training
    c. FRCE Stress First Aid Program
    d. FBHA Saving Those Who Save Others (includes Family Edition)
    e. IAFF Peer Support Training
    f. Mental Health First Aid
    g. Applied Suicide Intervention Skills Training (ASIST)

The following recommendations are identified as requiring a more formal level of engagement (i.e. staffing, resources, funding) and are deferred to a future cohort of the USFA Mental Health Workgroup:

1. Develop a summary document with current science-based recommendations of evidence-based interventions and best practices for their implementation.
2. Develop "accreditation" standards supported by the USFA for programs that specifically target the fire service (i.e. need to be validated for the fire service and meet national standards for utilization).
3. Identify source (s) to host, publish, and maintain a directory of wellness/prevention resources and validated treatment interventions for Fire/EMS personnel.
4. Advance a national coordinated strategy for dissemination of the directory of interventions and resources.

Monitor Predictors

Convene a sub-advisory panel charged to:

1. Identify validated assessment tools that adequately measure first responder mental health and occupational stress.
2. Identify further research needed in this area.
3. Identify a source to host, publish, and maintain a directory of identified assessment tools.
4. Advance a national strategy for dissemination of assessment tool directory.
5. Create implementation guidelines (toolkit) for departments to adopt annual mental health screening including those contained in the current NFPA standard.
6. The following instruments have been identified by the Workgroup as accepted and effective screening measures of mental health conditions that commonly impact Fire and EMS personnel, including PTSD, major depression, substance use disorder (SUD), and suicidal thoughts/ behavior.
    a. Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)
    b. PTSD Checklist for DSM-5 (PCL-5)

c. Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PHQ-2)
    d. Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PHQ-9)
    e. Columbia-Suicide Severity Rating Scale Screen with Triage for Primary Care (CSSR-S)
    f. CAGE-AID Questionnaire (CAGE)
    g. Alcohol Use Disorders Identification Test (AUDIT)
    h. Drug Abuse Screening Test- 10 (DAST-10)

These instruments are also recommended in NFPA 1582[22] as non-diagnostic screening options that can be used as part of annual behavioral health screening process for fire service personnel. Further research is needed to assess the specific value of using these assessment tools with Fire and EMS personnel. See Appendix C for further details.

7. Identify key metrics for tracking mental health and wellbeing program utilization by having departments report information to a national database; develop subsequent database for collecting and providing utilization data of mental health and wellbeing programs.

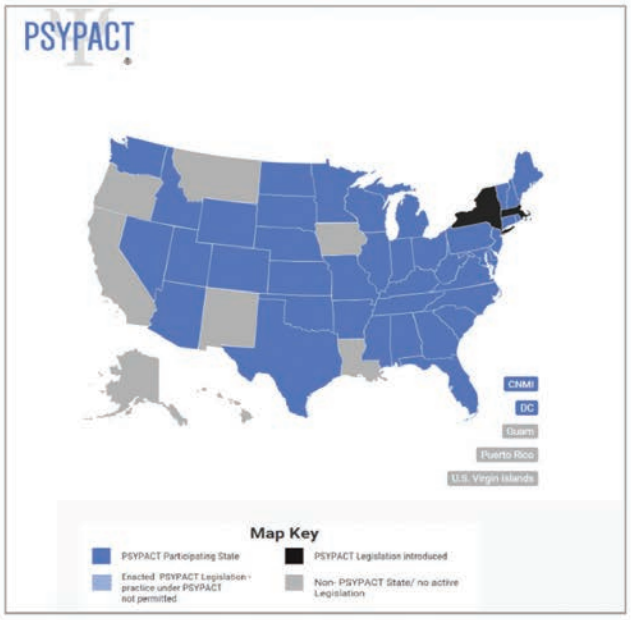
Funding

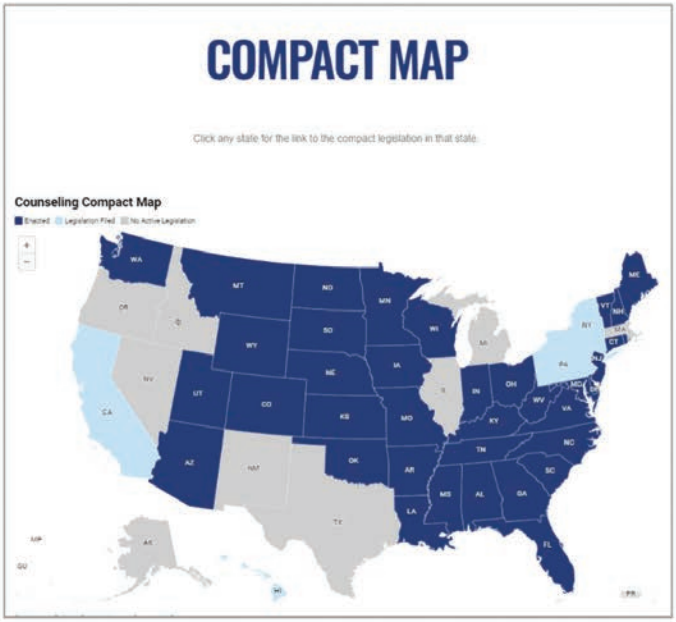
Convene a sub-advisory panel charged to:

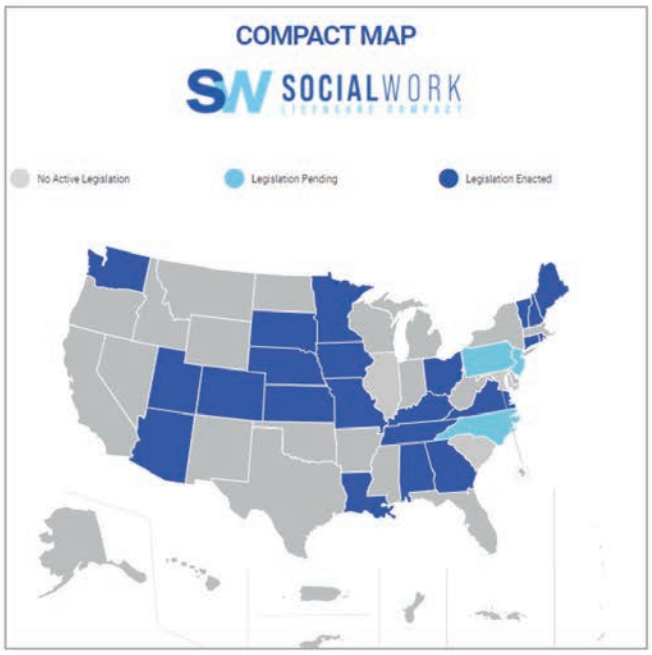
1. Recommend the types of funding needed to provide and monitor the success of infrastructure (access to programs, education for personnel, and dissemination) to embed mental health and wellbeing programs in Fire/EMS departments and organizations.
2. Identify sources of financial support for mental health and wellbeing programs of Fire/EMS personnel not covered by health insurance, or state and regionally funded programs.
3. Provide a guidance publication for departments and organizations on how to develop a robust grant proposal to acquire mental health and wellbeing programs.
4. Identify one source to host, publish, and maintain the database of applicable grants for evidence-based mental health programs and/ or research initiatives focused on first responder mental health.
5. Advocate for funding to support the development of large-scale, long-term cohort studies designed to identify predictors of suicidal ideation, depression, anxiety, and substance use/ abuse disorders among Fire/EMS personnel.
6. Create legislative toolkits for state fire service leaders to advocate and request state and local sustained resourcing for firefighter mental health and wellbeing services and programs.
7. Engage healthcare economists to evaluate the cost/benefit analysis of prevention and intervention programs across the spectrum of care and services in existence and contemplated in the future.

Appendix A

Adoption of interstate licensing compacts for mental health has progressed rapidly in 2023-2024. To date, a combined forty-two states and Washington, DC have enacted interstate compact legislation through the Psychology Interjurisdictional Compact (PSYPACT), the Counseling Compact, or the Social Work Licensure Compact. The maps below demonstrate the status of legislation for each licensing compact, as of July 31, 2024.







Appendix B

Core Characteristics for Mental Health Clinicians Working With Fire and Rescue Personnel

Mental health and wellbeing are central to the overall health, performance, and longevity of fire and rescue personnel. In today's fire service, there is an increased demand for specially qualified mental health clinicians who can effectively serve this population. Summarized in five domains below is a non-exhaustive list of core characteristics to consider when determining a clinician's suitability to work with fire and rescue personnel. These domains include cultural competence, occupational awareness, trauma-informed care, clinical best practices, and clinician accessibility.

- **Cultural competence** can be defined as the clinician's ability to understand and respect different values, attitudes, beliefs, and behaviors across diverse cultures and social groups, while effectively integrating these components into treatment delivery.[23] *A clinician that displays cultural competence in working with fire and rescue personnel will:*
  - Possess individual cultural awareness by regularly examining their own personal beliefs, assumptions, and norms, while refraining from imposing these on the fire service member.
  - Seek fire service education, experiential learning (i.e. ride alongs, fireground training, station visits, etc.), or possess considerable professional or familial experience with fire service members and/ or public safety professionals.
  - Appreciate the fire service community as a distinct subculture with established social norms, shared values, attitudes, and behaviors, which may or may not shape the client's attitude towards mental health services. The clinician can identify important similarities and key differences between fire and rescue professionals and other emergency responders (i.e. police, military, corrections, etc.).
  - Conduct a culturally informed assessment that incorporates knowledge of the fire service experience into case conceptualization, while staying focused on client's presenting problem and expectations for treatment. A culturally competent clinician will refrain from assuming their client identifies with all aspects of fire service culture, nor automatically attribute the client's distress to the occupation.
- **Occupational awareness** is related to cultural awareness, but not the same. Occupational awareness refers to a functional understanding of fire service operations. *A clinician who displays occupational awareness in working with fire and rescue personnel will:*
  - Display a basic understanding or desire to learn about daily operations of fire and rescue personnel, including common activities on shift, frequent types of service calls, fire service apparatus, and related terminology.
  - Is familiar with fire service rank as a para-military chain of command structure and can consider any psychosocial implications for the fire service client.
  - Can adapt treatment sessions around a rotating shift schedule, with flexibility as needed due to mandatory overtime, call-backs, staff shortages etc.
  - Recognize the direct impact of shiftwork on the fire service member's mental and physical health, sleep, relationships, family life, healthcare, leisure, etc.
- **Trauma-informed care** recognizes the impact of past trauma on an individual's well-being and how it can affect their neurological, biological, psychological, and social development, while aiming to prevent re-traumatization in delivery of care. Trauma-informed care encompasses six key principles, which can be summarized as 1) safety; 2) trustworthiness; 3) peer support; 4) collaboration; 5) empowerment/ choice; and 6) cultural, historical, and gender Issues.[24] *A clinician who provides trauma-informed care when working with fire and rescue personnel will:*
  - Explore how occupational trauma in the fire service may be impacted by a history of previous or childhood trauma, while not assuming that all fire service clients are coping with a traumatic response.

- Be trained and proficient in one or more therapeutic modalities that are recognized as evidence-based treatments for trauma. (See footnote for examples).
- Explain confidentiality with great care, including limitations of confidentiality that are relevant to public safety personnel seeking mental health assistance
- Offer a meeting space that strives to protect confidentiality, while minimizing opportunities for interaction with the public and/ or other public safety personnel.
- Incorporate peer support assistance as a supplement to treatment, while embracing the therapeutic value of lived experience in the fire service community.
- Collaborate with the fire service client to establish a personalized treatment plan with concrete goals that are meaningful to the client.
- Display professional integrity and transparency in all aspects of delivery of care.

- **Clinical best practices** reflect a combination of skills, standards, and approaches that benefit all client populations, but are especially important when working with fire and rescue personnel. This population may defer seeking care until they are in crisis, acutely symptomatic or functionally impaired, and thus will benefit from a direct therapeutic approach that empowers the client with a clear path forward towards recovery. *A clinician working with fire and rescue personnel should be prepared to:*
  - Encourage/ enable the fire service member to complete intake paperwork and any clinical scales before sessions, to maximize time spent with clinician during initial and subsequent sessions.
  - Complete the initial diagnostic evaluation/ assessment and tentative treatment plan within the first two sessions with the fire service member.
  - Utilize standardized time-limited interventions that allow the fire service member to anticipate treatment duration, track progress, and receive psychoeducation.
  - Be trained or proficient one or more interventions that are recognized as evidence-based treatments[25] for clinical depression, generalized anxiety, post-traumatic stress disorder/ acute stress reactions, substance use disorder, and marriage/relationship crisis.
  - Establish a clear plan for crisis care between sessions, to eventually include a complete suicide safety plan,
  - Have access to other mental health professionals for professional consultation as needed who also work with fire/ rescue or public safety personnel.
  - Secure explicit permission from fire service client to coordinate care as indicated with prescribers, intensive outpatient programs, inpatient programs, and fire department physician, etc.
- **Clinician accessibility** is critically important to fire and rescue personnel seeking mental healthcare. In their line of work, fire and rescue personnel are required to provide an immediate response to calls for service and often anticipate the same in return, when seeking mental healthcare. *A clinician who is accessible to fire and rescue personnel will:*
  - Respond to initial inquires for service within 24 hours and offer a limited number of next-day appointments when clinically indicated.
  - Provide a 15-minute consultation to the fire service member free of charge, to establish rapport and therapeutic fit, before asking the client to complete intake information.
  - Accept major insurance and/ or establish a sliding scale, as private pay is cost-prohibitive for many public safety personnel.
  - Provide telehealth services as an option to enhance convenience and privacy for fire service clients, while offering office visits for those who prefer in-person care. Consider if fire service member's access to home computer will be a barrier in delivery of care.
  - Use plain, concrete language with fire service client in all aspects of delivery of care.

Appendix C

The following instruments have been identified by the Workgroup as a non-exhaustive list of industry-recognized screening measures for PTSD, clinical depression, substance use disorder (SUD), and active suicidality.

- **Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)**
  Prins, A., Bovin, M. J., Kimerling, R., Kaloupek, D. G, Marx, B. P., Pless Kaiser, A., & Schnurr, P. P. (2015). *Primary Care PTSD Screen for DSM-5 (PC-PTSD-5). Retrieved from* https://www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf

- **PTSD Checklist for DSM-5 (PCL-5)**
  Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). The PTSD Checklist for DSM-5 (PCL-5). Retrieved from https://www.ptsd.va.gov/professional/assessment/documents/PCL-5_Standard.pdf

- **Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PHQ-2)**
  Pfizer Inc (1999). Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PHQ-2 & PHQ-9). Retrieved at http://www.cqaimh.org/pdf/tool_phq2.pdf

- **Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PHQ-9)**
  Pfizer Inc (1999). Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PHQ-2 & PHQ-9). Retrieved at http://www.cqaimh.org/pdf/tool_phq9.pdf

- **Columbia-Suicide Severity Rating Scale Screen with Triage for Primary Care (CSSR-S)**
  The Columbia Lighthouse Project (2016). Columbia-Suicide Severity Rating Scale Screen with Triage for Primary Care (CSSR-S). Retrieved at http://cssrs.columbia.edu/documents/c-ssrs-screener-triage-primary-care/

- **CAGE-AID Questionnaire (CAGE)**
  Brown (1995). CAGE-AID Questionnaire. Retrieved at http://www.cqaimh.org/pdf/tool_cageaid.pdf/

- **Alcohol Use Disorders Identification Test (AUDIT)**
  World Health Organization (1982). Retrieved at Alcohol Use Disorders Identification Test https://www.drugabuse.gov/sites/default/files/files/AUDIT.pdf.

- **Drug Abuse Screening Test- 10 (DAST-10)**
  Addiction Research Foundation, (1982). Drug Abuse Screening Test (DAST–10). Drug Abuse Screening Test (DAST–10). Retrieved at http://www.bu.edu/bniart/files/2012/04/DAST-10_Institute.pdf.