FRBH IMPLEMENTATION GUIDANCE

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Getting Started with Occupational Psychological Hazard Protection

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No conformity assessment, certification, or accreditation program operates against the Standard. Organizations determine their own conformity by self-assessment under Chapter 3 of the Standard.

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Related Publications:

FRBH National Standard for OPHP (FRBH-OPHP-003)

FRBH Executive Overview (FRBH-EB-002)

FRBH Organizational Self-Evaluation (FRBH-OSA-002)

FRBH National Technical Assistance Center (FRBH-NTAC-002)

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About This Guidance

This publication describes how organizations commonly put the expectations in Chapter 2 of the Standard into practice. It is informative. It establishes no requirement, and nothing in it is necessary for conformity — an organization may conform to the Standard without ever reading this document.

Organizations differ in size, governance structure, mission, operational environment, and available resources. Implementation pathways vary accordingly. The examples here are illustrative and do not prescribe a single model. This publication is not legal advice; Chapter 4 of the Standard identifies the areas of law that warrant review by counsel licensed in your jurisdiction.

The shape of the work

Implementation is mostly documentation and coordination, not construction. Most organizations already do some version of what the Standard asks — informally, inconsistently, and without a record. The work is to make it explicit, assign it, and put it on a schedule.

Two things about that are worth saying at the outset. First, the Standard does not ask you to build a behavioral health program; it asks you to build the governance layer that connects a known exposure to the capabilities you already have. Second, the hardest single step is usually Section 2.2 — writing down what counts as a qualifying exposure. Annex H.1 of the Standard exists so that this does not have to be done from a blank page.

It is worth knowing why the work takes this shape. The Standard addresses one question: when a qualifying exposure has occurred, what protection does the organization provide to the worker? (Section OPHP.1.1.1.) It begins at the point of exposure and follows established post-exposure practice: as in a bloodborne pathogen program, a defined exposure triggers organizational follow-up before any harm is present, and the duty to act falls on the organization rather than on the exposed person. What the organization provides is organizational, not clinical: recognizing that a qualifying exposure occurred, notifying those responsible, coordinating the capabilities it already has, telling affected personnel what is available and that participation is voluntary, protecting them from reprisal, and recording what was done. That is why almost everything below is about writing something down and assigning it, rather than about building a service.

The Standard does not cover what comes before exposure. Assessing hazards or work environments, designing work, staffing, assignment practice, and other measures intended to prevent or reduce exposure are recognized occupational safety activities, but they are outside the Standard's scope. Nothing in this guidance asks you to undertake them, and conformity neither depends on them nor demonstrates them. Nor does the Standard claim to prevent post-traumatic stress disorder or any other condition.

Choose your track first

Annex H.3 of the Standard describes scaled pathways. Conformity does not vary by organizational size (Section 3.2); what varies is how the work is sequenced and how much of it can be folded into existing roles.

Track	Applies to	What changes
Track 1	Under approximately 25 personnel, or all-volunteer	Combine the governance role with an existing officer position. Adopt Tier 1 criteria largely as-is. Satisfy the communication requirement at a shift briefing or membership meeting recorded with a date and attendance. Use mutual-aid or regional resources for coordination. Conduct the leadership review as a brief documented review rather than a standing committee. Combine the activation exercise with an existing mutual-aid drill.
Track 2	Approximately 25 to 150 personnel	Standard implementation as written, with the governance role assigned to a specific existing officer rather than a new hire.
Track 3	Approximately 150 or more, or multi-station/multi-shift	Full implementation as written. A dedicated governance function is likely warranted, and cumulative-exposure criteria should be supported by existing CAD or records-management data.

Phase 1 — Governance (Section 2.1)

Nothing else works until someone owns this. Section 2.1 requires executive accountability assigned to a named individual with defined authority, distinguishable implementation and oversight responsibilities, identified responsibility for evaluation, and provision for re-designating the accountable executive without undue delay if the role becomes vacant.

How organizations commonly do this

- Assign the role to an existing officer rather than creating a position. A deputy chief, an operations commander, a safety officer, or a risk-management lead are all common choices.
- Put the designation in writing, dated and signed by the executive authority. An organizational chart alone is not evidence of a designation (Annex A).
- Integrate OPHP governance into an existing occupational safety, occupational health, wellness, behavioral health, or risk-management structure instead of standing up a parallel one.
- Write the vacancy provision into the same document. It exists because the governance review interval runs to 24 months — without it, an accountable-owner vacancy could sit open for most of a review cycle while the organization remained technically conformant.

Note

Assigning OPHP to a committee without naming an individual. Section 2.1(a) requires executive accountability, and a committee is not an accountable executive.

Phase 2 — Qualifying OPHE Criteria (Sections 2.2 and 2.2.1)

This is where most implementation time goes. The criteria are the organization's written answer to a single question: which exposures trigger an organizational response?

Start from the floor, not from zero

Section 2.2.1 fixes four categories the criteria may not be drawn narrower than: any line-of-duty death; any mass casualty incident at a threshold the organization defines; any pediatric fatality encountered in the course of duty; and any incident resulting in serious injury or death to organizational personnel. These correspond directly to Tier 1 of the model criteria in Annex H.1. Adopting Tier 1 satisfies Section 2.2.1 without additional drafting.

Where a floor category needs a number — a mass-casualty threshold, for instance — that number must be documented and supported by the organization's mission, operational environment, foreseeable exposure profile, and incident history. A threshold set high enough to materially limit activation, without a documented operational basis for it, is objective evidence of nonconformity. Set thresholds against what actually happens in your jurisdiction, not against what you can comfortably absorb.

The three-tier structure

Tier	What it does	Why it is built this way
Tier 1 — objective single-event triggers	A closed list of event types that qualify automatically, with no supervisor judgment.	These are verifiable from records you already keep. Activation can piggyback on the existing incident report rather than requiring a new system.
Tier 2 — cumulative exposure proxies	Objective count-based thresholds drawn from operational data you already maintain — a number of fatality or serious-injury responses in a rolling window, or a sustained-deployment threshold.	Repeated exposures accumulate without any one event meeting Tier 1. A count-based proxy avoids asking a supervisor to judge when someone has had “enough.”
Tier 3 — discretionary safety net	A supervisor, peer support member, or the individual themself may request activation where Tier 1 and Tier 2 are not met, without justification tied to diagnosis or symptoms.	Objective tiers must not become a ceiling. This is one way of providing the route required by Section 2.2(g).

Adapt Tier 2 to the discipline, not just the numbers

The Tier 2 proxies are built around discrete, scene-based incidents and transfer directly to fire, EMS, and law enforcement response. Other disciplines within scope need the mechanism changed, not just the threshold.

- **Public safety communications and dispatch:** exposure is call-based rather than scene-based, often with no visible outcome and no immediate debrief. A count of calls in a rolling window involving active

violence, a child victim, a suicide in progress, or a caller's death during the call is a more accurate proxy than a response count.

- **Corrections:** exposure is frequently chronic and environmental rather than event-based. A duration-based proxy — continuous assignment to a high-security or high-incident unit for a defined period — fits better than an event count.
- **Emergency management:** exposure accumulates through extended single deployments. The sustained-deployment proxy is usually the primary mechanism, and a rolling response count may not apply meaningfully.

Consultation is required, not optional (Section 2.2(j))

The criteria must be developed, and reviewed at each cycle, with documented consultation of the personnel who encounter the hazards and, where personnel are represented, their designated representatives. This mirrors the worker-consultation requirement in comparable occupational safety management-system standards.

Consultation does not require agreement and does not move responsibility for the criteria away from the organization. What it requires is that the people the criteria cover have an opportunity to comment before adoption and at each review, and that the opportunity is documented — who was consulted, when, and how. Criteria written without the people they cover tend to be both inaccurate and resented.

The cumulative-exposure decision (Section 2.2(k))

Section 2.2(k) gives two conforming paths. Either include at least one cumulative or repeated-exposure criterion, expressed as a threshold you can verify from data you already maintain — or document the absence of one as a known limitation, together with a target date for addressing it.

If your records system cannot currently support a rolling count, take the second path and write it down. Recording a limitation with a date is conforming. Leaving the gap undocumented is not.

Communicate them (Section 2.2(h))

Criteria that exist but were never distributed are among the most common insufficiencies listed in Annex A. Personnel who do not know what qualifies cannot recognize when activation should have happened and did not, and cannot use the request route in Section 2.2(g). Record the distribution with a date and a method.

Phase 3 — Activation (Sections 2.3 and 2.3.1)

Section 2.3 requires a documented procedure and — importantly — implementation of that procedure as documented when qualifying OPHE is recognized. A written procedure that is not followed is not conformity.

Fix the recognition point (Section 2.3(a))

Everything downstream runs from the moment of recognition, so the procedure must say who recognizes and at what point. This is easy to get subtly wrong. Where recognition is attached to a document produced well after the incident — an end-of-shift report, say — the interval between exposure and coordination can be long even though the organization meets its own stated timeframe. Attach recognition to something that happens close to the event: the dispatch record, the incident type code, the on-scene supervisor's initial notification.

Set the timeframe yourself (Section 2.3(g))

The Standard does not prescribe an interval, because appropriate intervals vary by discipline, staffing model, and incident type. It requires that you state one. Whether a fixed outer limit should replace the organization-defined timeframe in a future edition is an open question stated in Annex I.

Decide who counts as affected personnel

The organization determines who is included. The definition in the Standard names the categories most commonly overlooked: telecommunications personnel who handled the incident, personnel who responded in a supporting or secondary role, and others exposed in the course of duty without being physically present at a scene. Write the rule down before you need it.

Tell people what is available (Section 2.3(h))

This is the minimum content of activation. An organization that recognizes a qualifying exposure and coordinates capabilities without the affected personnel learning what is available to them has not completed activation. The communication must also state that participation is voluntary. A notice that the organization has activated OPHP following an exposure is readily heard as a direction to attend something; saying what is available, how to reach it, and that the choice belongs to the individual forecloses that reading at the point where it would otherwise form.

Exercise it (Section 2.3.1)

Qualifying OPHE may occur infrequently, which means activation procedures can go untested for years. Section 2.3.1 requires a tabletop or simulated exercise at intervals not exceeding 24 months, testing notification, coordination, and documentation steps as though a qualifying exposure had occurred, documented with the date, participants, and any resulting corrective action. A genuine activation within the preceding 24 months may substitute for that cycle.

Smaller organizations may combine this with an existing mutual-aid or regional training exercise rather than running it standalone, provided the combined exercise still tests all three steps and is documented.

Phase 4 — Coordination (Section 2.4)

This phase is an inventory problem before it is a process problem. Section 2.4 asks what capabilities are actually available and reachable — not what is contracted, and not what existed two years ago.

- Inventory what exists: EAP, peer support, chaplaincy, occupational health, wellness, clinical referral pathways, mutual-aid and regional arrangements.
- For each, record who coordinates it, how it is reached, and what it can actually deliver — response time, capacity, scope.
- Define referral pathways where applicable, and how continuity is maintained beyond first contact.
- Preserve voluntary participation, except where law or an applicable collective bargaining agreement requires otherwise.
- Review the inventory at least every 12 months (Section 3.6(g)). Contracts lapse, team members leave, and memoranda expire; an inventory nobody maintains becomes a list of phone numbers that do not answer.
- Where standalone capability is not practical, mutual-aid, regional, or county-level resources satisfy this section — a shared peer support team, a regional EAP contract.

Phase 5 — Confidential Access and Reprisal Protection (Sections 2.5 and 2.5.1)

Take this phase to counsel and to labor representatives before finalizing anything. Annex H.5 of the Standard is a short checklist written to be handed over directly.

Confidential access

- Provide at least one pathway personnel can use without routing the request through the chain of command.
- State the limits of confidentiality plainly and accurately for your jurisdiction. Overstating protection is worse than stating it narrowly, because it will be discovered at the worst possible moment.
- Confirm how any state peer-support or critical-incident confidentiality statute applies to your coordinated capabilities, and what exceptions it carries.
- Reconcile with any existing EAP, peer support, or CISM provisions already in a collective bargaining agreement rather than creating a second, potentially conflicting system.

Protection from reprisal

Section 2.5.1 requires a documented policy that personnel are not subject to adverse organizational action for being identified as having experienced qualifying OPHE, or for their participation, non-participation, or degree of participation. It must be communicated to personnel, and — under 2.5.1(c) — activation and participation information must not be held in personnel files or performance evaluation records unless law requires it there.

That last requirement usually has a records consequence. Decide where activation information does live, document that decision, and make sure the practice matches what you told personnel. Chapter 4.5 of the

Standard describes a tiered structure — conformity records carrying category, date, and disposition only, with incident-specific detail remaining in existing operational systems under existing access controls — as one recognized way of reducing public-records disclosure risk while still satisfying the evidence requirements.

Nothing in Section 2.5.1 limits fitness-for-duty determinations, disciplinary processes, or employment decisions made on grounds independent of OPHE recognition or participation. Where an organization relies on independent grounds, it should be able to identify those grounds from records created before the recognition or participation at issue. And nothing in the Standard waives or substitutes for any right, remedy, or procedure available under law or a collective bargaining agreement.

Rationale

If personnel believe activation carries career risk, they will avoid the system regardless of what the policy says. Annex H.6 of the Standard addresses cultural resistance directly.

Phase 6 — Oversight, Evaluation, and Improvement (Sections 2.6 to 2.8)

These three sections are where implementation becomes a system rather than a project. Their intervals are fixed in Section 3.6 and are not left to judgment.

Section	Interval	What the review has to actually do
2.6 Leadership oversight	6 months	Address implementation, activation activity, effectiveness, and barriers — not simply receive a status report. Initiate and track corrective action where problems appear.
2.7 Organizational evaluation	12 months	Produce a documented finding, not only a data table. Identify both strengths and improvement opportunities, and communicate results to leadership with a date and a named recipient.
2.8 Continual improvement	12 months	Show a traceable line from a specific evaluation finding to a specific change, that the change was implemented rather than only approved, and that its effectiveness was later evaluated.

An organization that has not conducted a required review within the defined interval is nonconforming with the corresponding expectation as of the date the interval lapses, regardless of whether the underlying program continues to operate. Put these on a calendar at the start.

Phase 7 — Self-Assessment (Section 2.9 and Chapter 3)

Section 2.9 requires a documented self-assessment at intervals not exceeding 12 months, reaching a determination at the level of each expectation. The FRBH Organizational Self-Evaluation workbook (FRBH-OSA-002) is built for this purpose.

Two points about a first self-assessment. An organization within its first cycle is not nonconforming for a review that is not yet due — record that fact rather than deferring the self-assessment entirely. And where no qualifying OPHE has occurred, the activation exercise under Section 2.3.1 provides the evidence that the procedures function as documented.

Classify what you find using Section 3.8.2 as written. A major nonconformity requires a documented corrective action plan with a defined resolution period; a minor nonconformity requires a plan tracked to closure. Overall conformity is achieved when there are no unresolved major nonconformities and every minor nonconformity has a documented plan.

A 90-Day Fast-Start Sequence

Annex H.4 of the Standard compresses the phases above into a concrete timeline, assuming the organization is building on existing resources rather than starting from nothing. Actual timelines vary with size, governance, labor requirements, and existing capability.

Days	Work
1–15	Leadership designates the OPHP governance owner (2.1). Inventory existing EAP, peer support, chaplain, and occupational health resources (2.4).
16–30	Adopt and adapt the Tier 1 model criteria to the organization's actual risk profile. Draft the activation and notification procedure (2.3), including the recognition point required by 2.3(a) and the timeframe required by 2.3(g), integrating existing dispatch, supervisory, and incident-management processes.
31–45	Communicate to the workforce what qualifies (2.2(h)), what happens automatically, how to request activation where the criteria are not met (2.2(g)), that participation remains voluntary, and how confidentiality is protected (2.5).
46–60	Leadership sign-off on the governance policy. Brief labor representatives and legal counsel using the checklist in Annex H.5.
61–90	Conduct the first leadership oversight review (2.6). Record the 2.2(k) determination — either the cumulative criterion adopted, or the limitation and its target date.

The Minimum Documentation Set

Organizations often ask what the smallest defensible document set looks like. Annex A of the Standard gives seven items which, maintained currently and reviewed on the Section 3.6 intervals, will typically cover Chapter 2 for an organization of any size.

1. Governance policy and executive designation (2.1).
2. Qualifying OPHE criteria, incorporating the Section 2.2.1 floor and the discretionary request route, with the record of their distribution to personnel (2.2).
3. Activation and notification procedure, including the documented timeframe (2.3).
4. Activation exercise record, or activation after-action record (2.3.1).
5. Capability inventory and coordination procedure, with any memoranda of understanding and the record of its periodic review (2.4).
6. Confidentiality policy, reprisal protection, and workforce communication record (2.5, 2.5.1).
7. A single review file holding the leadership oversight reviews, the annual evaluation, improvement actions, and the conformity self-assessment (2.6 through 2.9).

Common Implementation Pitfalls

- **Building a parallel system.** The Standard coordinates existing capabilities. Organizations that stand up a separate structure alongside their EAP and peer support tend to create work without creating protection.
- **Writing criteria in a room with no responders in it.** Section 2.2(j) requires consultation, and the practical reason is that the people closest to the hazard know what actually warrants a response.
- **Setting the mass-casualty threshold by capacity rather than by exposure.** A threshold that materially limits activation without a documented operational basis is evidence of nonconformity, not efficiency.
- **Undated documents.** The single most common evidence failure. A complete, undated policy is insufficient under Section 3.7(a).
- **Recognition attached to a late document.** If recognition happens at the end-of-shift report, coordination happens after the shift ends.
- **Treating the request route as a formality.** Section 2.2(g) requires a route usable by the affected person directly. It also matters for the converse workers' compensation risk described in the Standard — once criteria and activation records exist, a failure to activate where your own criteria applied is a gap the organization created itself.
- **Letting an interval lapse quietly.** Nonconformity attaches on the date the interval lapses, not on the date someone notices.

Where to Get Help

The FRBH National Technical Assistance Center is open and free. It answers general questions about the Standard and about FRBH through three channels: Ask FRBH, the chat assistant at www.frbh.org; email at support@frbh.org; and scheduled calls, booked at 844-ASK-FRBH (toll-free). Support is provided on the same terms to every organization and without regard to whether an organization is seeking or holds any conformity determination. FRBH-NTAC-002 describes it in full.

What the NTAC will not do is evaluate your specific documents, criteria, or evidence, or tell you whether you conform. That boundary is required by Section 3.9 of the Standard, and it is why the Organizational Self-Evaluation (FRBH-OSA-002) is built for the organization to complete itself. FRBH does not provide readiness, consulting, training, or advisory services, and does not assess, certify, or accredit any organization.

Comments on this edition of the Standard, including from organizations that do not intend to adopt it, go to info@frbh.org — the address the Standard gives for comment — and are logged on receipt.

The FRBH Publication Set

Six publications support implementation of the Standard. Only the Standard is normative.

Publication	Number	Purpose
FRBH Executive Overview	FRBH-EB-002	Strategic overview for chief executives, boards, and elected officials
FRBH National Standard	FRBH-OPHP-003	Establishes the organizational expectations. The only normative publication

Publication	Number	Purpose
FRBH Organizational Self-Evaluation	FRBH-OSA-002	Worksheet for reviewing organizational capability against Chapter 2
FRBH Implementation Guidance	FRBH-IG-002	How organizations put the expectations into practice
FRBH National Technical Assistance Center	FRBH-NTAC-002	The open, free general-information service — Ask FRBH chat, email, and 844-ASK-FRBH
FRBH Frequently Asked Questions	FRBH-FAQ-002	Practical questions about adoption and conformity

There is no accreditation publication, because FRBH does not operate an accreditation program and does not intend to establish one.

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