Promoting Mental Health in the Watertown Fire Department

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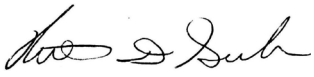
Certification Statement

I hereby certify that this paper constitutes my own product, that where the language of others is set forth, quotation marks so indicate, and that appropriate credit is given where I have used the language, ideas, expressions, or writings of another.

Signed: 

Abstract

The fire service has evolved since it inception taking on different roles and tasks need to be filled by the public. Why, when an internal issue is identified can't the service step up and lead its self towards a solution.

The problem is that the City of Watertown Fire Department (WFD) has not identified what the components of a mental health program should include. The purpose of this study is to identify components of a mental health program that should be provided by the Watertown Fire Department

This research used the descriptive method to identify what should be covered in a program meeting the needs of the WFD. This paper answered the following questions: What services should or could be offered to members in need of assistance with regards to mental health? What are the current best practices in the fire service related to mental health programs? What education and training is available to assist with the identification of symptoms and treatment options?

This research distributed questionnaires to the members of the WFD and other departments throughout the United States. This was done to find what the members of the WFD expected from a program and what other departments were doing to address this issue. The City's employee assistance program was looked at to evaluate its services and the services covered by the City's insurance plan. The results showed that the WFD has some of the components of a mental health program already in place but lacks organization and department involvement. The recommendations were to establish a behavioral health committee to organize the current components, establish procedures for the future, start a peer support program, and identify mental health professionals in the area to recommend to its members.

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Promoting Mental Health in the Watertown Fire Department

Introduction

One does not have to look far to find an article or story about a mental health issue in the fire service today. This does not mean it was not an issue before but, we as a service either ignored the signs or covered them up. Many firefighters would not let on that anything was bothering them, put on a strong face around the station. Firefighters that were showing signs of some kind of issue were told to "man up" or the signs ignored altogether. We have come to a time in history where those responses are unacceptable. The City of Watertown Fire Department is no different, and they have not been immune to these issues. The unfortunate consequence is that the WFD has lost two members from their own hands.

The problem is that the City of Watertown Fire Department (WFD) has not identified what the components of a mental health program should include. It is time to admit that we are not invulnerable from our thoughts and start dealing with them in a healthy way instead of suppressing them. The purpose of this study is to identify components of a mental health program that should be provided by the Watertown Fire Department.

This research used the descriptive method to identify what should be covered in a program meeting the needs of the WFD. This paper does answer the following questions: What services should or could be offered to members in need of assistance with regards to mental health? What are the current best practices in the fire service related to mental health programs? What education and training is available to assist with the identification of symptoms and treatment options?

Background and Significance

The City of Watertown is the county seat for Jefferson County located in Northern New York. The city is 9.4 square miles and has 25,900 residents. Watertown is located on the US Route 81 corridor 70 miles north of Syracuse and 30 miles south of the Canadian border.

The WFD celebrated its bicentennial this year since the first fire protection in Watertown was established in May of 1818. The WFD is a full career department with 68 budgeted staff. The 63 line personnel are assigned to four shifts working a rotating schedule of three 10 hour days, three days off, three 14 hour nights, three days off. The remaining personnel are the fire chief, deputy fire chief, a captain assigned to training, and two members assigned to the codes department who all work a typical work week. The WFD is contractually obligated to be staffed at 15 members at all times but, as a result of a motion by the council in November of 2017, the department no longer backfills for members out on short-term sick leave down to 13 members on duty. There are currently seven members on long-term illness or on the job injury. The department has not hired new firefighters since 2012. This reduction in force along with long-term injuries has increased the demand for overtime drastically even with the decrease in minimum staffing. The department responds to approximately 4400 calls for service each year. (City of Watertown management team, 2018-2019, p. 93)

A recent study found that more firefighters died from suicide in 2017 than in the line of duty. Nationwide at least 103 firefighters died by suicide as opposed to 93 in the line of duty. The WFD although not part of that statistic has a loss of their own in 2018. A firefighter of over 30 years retired in January and took his own life in June. This was not the first time the WFD has been struck by this plight either in the fall of 1996 a firefighter committed suicide as well. The best way we can tribute these fine men is to help one another and prevent this from happening

again. The national average for firefighter suicide is currently at 18/100,000 compared to 13/100,000 of the general population. Recognition of this issue is real and needs to be addressed. (Heyman, Dill, & Douglas, 2018, p. 19)

This research is a direct reflection of the USFA Goal three: Enhance the Fire and Emergency Services Capability for Response to and Recovery From ALL Hazards. Key Initiative number 3 reads: Promote a culture of health, wellness, and behavior the enhances emergency responder safety and survival. This applied research paper (ARP) is doing just that; it is a study of what is needed to make a cultural shift to a more accepting environment with regards to mental and behavioral health. (USFA, 2014-2018, p. 12) This study is also relevant to the Executive Leadership course with regards to the sections relating to giving and using feedback as well as influence and persuasion. The mental health issues require members of the fire department to be astute to their fellow firefighters recognizing when someone is not dealing with something efficiently and listening to them and giving feedback along with persuading them to seek help if need be.

Literature Review

In this research, the terms of mental and behavioral health are used interchangeably or in conjunction with each other. The term mental health is defined by Webster's dictionary as "health care dealing with the promotion and improvement of mental health and the treatment of mental illness."("Definition of mental health," 2018, para. 2)The term behavioral health is a blanket term that includes mental health but is not limited to only the mental aspect. Behavioral health can be a physical or mental illness but also includes such things as substance abuse, treatment and recovery, and forms of counseling. (Neese, 2016, para. 7,8)

The fire service looks to the National Fire Protection Association (NFPA) for many of its industry standards. In a review of these standards, two were found that speak to mental or behavioral health. The first standard is 1500 - Fire Department Occupational Safety Health and Wellness Program chapter 12 is behavior health and wellness programs in that chapter there are a number of requirements starting with providing access to such a program to its members. The programs shall include things like traumatic exposures, post-traumatic stress, depression and grief, stress management, substance abuse and resiliency training to name a few. This chapter also speaks to a members fitness for duty and that such fitness should be evaluated. The program shall be written out in policy and any records be strictly confidential. Education and training with regards to these topics should begin in recruit school and continue into retirement.(National Fire Protection Association [NFPA], 2018, p. 34,58) The next standard referenced is 1582 - Standard on Comprehensive Occupational Medical Program for Fire Departments in chapter nine covers psychiatric and psychologic disorders and substance abuse are addressed. This chapter lists some conditions that could affect a members ability to perform job functions. The standard recommends further evaluation my either a physician or mental health professional to assess a members ability and make recommendations if accommodations need to be made. (National Fire Protection Association [NFPA], 2018, p. 39-40)

The National Fallen Firefighters Foundation (NFFF) has identified the need for processes and programs to be in place to assist firefighters and their families cope with the stress of the job. In their 16 life safety initiatives, they have listed number 13 psychological support as a priority. This initiative states that firefighters and their families must have access to counseling and psychological support. As part of this initiative, they have created posters and other marketing tools reminding us to take care of each other. Suggesting a protocol for exposure to occupational

stress which is a process to follow to assure our members get assistance if they need it. The protocol includes things like allowing a timeout period before returning to duty, a trauma screen questionnaire and possibly a referral to the behavioral health assistance program. Along with this initiative, the NFFF has developed the Fire Service Behavioral Health Management Guide and has listed this guide as a resource in developing a program. They have also developed some classes to assist in training members. (National Fallen Firefighters Foundation [NFFF], 2011, p. 1-4)

The behavioral health management guide is broken down into four parts, leadership, firefighters, peer support, and clinical support. Leaders on all levels must support this movement in order for this to be effective, from department management to union leaders and the informal leaders within the department. Leaders need to start with education to be able to explain and identify why a program is needed. They have to lead the change reducing and eliminating the stigma related to mental health. Part of this acceptance could be by calling the program by a different name and assuring confidentiality. Official leaders within the department may not be the most appropriate people to champion this cause seeking out those members that are is important. Finding local resources that have some experience working with emergency responders and identifying who the program is intended to serve. As the families of firefighters many times suffer with their loved ones, consideration should be made to provide some form of family support. Leadership should be willing to allow those champions to develop a following, giving them the space needed to develop and build support for the program, allowing this movement to change the culture of the department supporting each other.(National Fallen Firefighters Foundation [NFFF], 2017, p. 11-13)

For firefighters, there are steps they can take in the event of a lack of a program. They can start by educating themselves with the importance of self-care, the need to take time to identify personal response to the stimulus and the effects of cumulative stress and what prevents them from practicing self-care. Often time this is putting others needs ahead of their own leaving no time for themselves. The culture needs to change to think of self-care much like the need for training for a fire. This is no different than doing a drill or working out at the gym; our mental wellbeing is just as important as our physical. Changing the culture towards feeling free to talk with one another and asking if each other is alright when they seem to need support. If the leadership is not moving towards a behavioral health program, firefighters should start a grass routes campaign, urging them to start a program. Do some research, does the department already have an employee assistance program (EAP), does employee health insurance cover mental health services, and what providers in the area may have experience with first responders. The ACT now campaign falls under these firefighter roles, ACT stands for Ask Care Take. Ask someone how they are feeling, tell someone you care about their well being and take them to get the help they need.(National Fallen Firefighters Foundation [NFFF], 2017, p. 15-17) The ACT program is based on a program being used by the US Army known as ACE. Ask your buddy, Care for your buddy, and Escort your buddy. ACE is a four-hour awareness level course for soldiers assisting them to identify the warning signs of suicide.(Gervasoni, 2010, para. 5-6)

Peer support is a valuable tool in the overall program. Peer support councilors are specially trained firefighters that understand what their fellow firefighter are going through. Their training should include awareness and recognition of the signs and symptoms of stress and what resources are available and how to get to them. They should be activated in the event of a high-stress incident such as a mass causality incident, suicide or attempted suicide of a member.

Peer support members should be available on an as-needed basis that may or may not be job-related. Staff should know who they are and how to reach these members. Most importantly everyone needs to know that their communication is confidential to maintain trust in the program. (National Fallen Firefighters Foundation [NFFF], 2017, p. 19-20)

The final component in the guide is clinical support; there are times when peer support or support of our fellow firefighters is not enough, and there is a need for a therapist. This is where research is needed to find a provider that has an understanding of the unique nature of experiences the firefighter and first responders face. Finding a provider that may be will to adjust their schedule to work within the fire service shift work can be a challenge. Many firefighters resist going to a therapist for a few reasons starting with the culture of the organization, then the fear that they may be removed from duty and their confidentiality is then lost. This guide offers a list of questions to consider when looking for a local clinician and urges that you don't give up and understand that not all therapists are trained the same. The guide also recommends the use of chaplains as a resource, their assistance as part of the program and in planning phases of the program can be valuable.(National Fallen Firefighters Foundation [NFFF], 2017, p. 22-24)

This guide offers a list of resources that could be used in setting up a program and classes available to assist in training. Coursework that is provided by the NFFF like the stress first aid courses and suicide resources. There are courses listed from other organizations as well, the International Association of Fire Chiefs (IAFC), International Association of Fire Fighters (IAFF), and National Volunteer Fire Council offer programs and courses that should be considered. (NFFF, 2017, p. 30-32)

Suicide in the fire service is a real threat. The days of "man up" or "Suck it up and deal with it" have to be over. It is time to recognize the issue and create programs and provide

training to deal with the problem. Firefighters are good at disguising their problems putting on a good face at the station and the small ques that would normally indicate they are having a problem are overlooked. Without awareness training, the warning signs are difficult to spot. Training programs should include a number of subjects starting with awareness level training in behavioral and emotional distress situations, signs and symptoms of these situations including addiction, depression, and PTSD. Programs should include the development of a peer support group, seeking appropriate mental health services tailored to the fire service, changing the culture to be non-judgmental and learning why mental health practices are important to our overall health. These practices include self-care, conflict resolution, stress management, and proper sleep habits. Behavioral health and mental wellness training is just as important as ladder or hand line training and should be treated as such. Training in these areas should begin during recruit training and continue throughout a career. (McGowan & Dutton, 2016, p. 6)

Investing in the mental health of the fire department makes good sense. Workplaces that support good mental health have better recruitment and retention, employees use fewer sick days, have fewer on the job injury claims, and have better morale. Research has shown a return on investment of $2.30 for every dollar spent on creating a mentally healthy workplace. Creating a healthy workplace can be broken down into six sections: strategy and program development, workplace campaigns, education and training, mental health providers, intervention and treatment, and data and evaluation. Strategy and program development involves ensuring leaders support improving mental health, adopting a management system approach, identifying stakeholders to develop strategies, programs and policies tailored to the workplace, and making sure strategies focus broadly on mental health. Workplace campaigns are to identify and use champions for mental health and implement campaigns to change the stigma helping

members seek and receive help when needed. Education and training comes in a few different forms, training employees on resiliency and mental health literacy. Train supervisors and managers (chiefs and line officers) with the skills to identify signs and symptoms to support employees. Mental health providers is finding a network of providers and helping them to understand first responder culture. Intervention and treatment starts with confidentiality and health care coverage to seek treatment. Peer support services is an in-house program to give employees an avenue to ask for help and provide those services to active, retirees and family members. Use of training to recognize the signs and symptoms of issues and take action as well as critical incident stress debriefing and conflict resolution. Lastly, data and evaluation, use data to identify issues in the fire department and prepare for evaluation from the start to assure desired goals are being met.(BC First Responders' Mental Health, 2016, p. 3-5)

Most firefighters don't even realize that the nature of their business is hard on their mental health. Their erratic sleep schedules and repeated exposure to traumatic stimulus poses a risk to their mental well being. To further compound that risk they also face barriers to getting the help they need. The culture of the fire service has a stigma on asking for help with regards to mental health and in some cases the cost of getting that treatment. Suicide and suicidal ideation among firefighters is much higher than the normal population. When studied firefighters ideation rate was 46.8% plans of suicide was 19.2%, and attempts were 15.5%. Comparatively, when police officers were studied for suicidal ideation, the rate was found to be about 24%. In both cases higher than the general population where ideation runs at 13.5% plans at 3.9% and attempts at 4.6%. (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018, p. 5-7)

There are interventions that can be done to help with reducing behavioral health risks for first responders. On the preparedness side, before an incident, planning for an incident with protocols and plans to deal with the disaster. It is important for responders to feel prepared for an incident, the sense of doing a good job helps with resiliency. Including all team members in the development of those plans and protocols, creates confidence in the team and reduces stress during the event. Use a command system with a clearly defined chain of command with the welfare of the response teams as the top priority. Prepare responders for the potential of what they may experience. On the response side when the incidents occur develop clear lines of communication. Leaders should be assessing the wellness of their teams throughout the event, rotating crews and resolving conflicts as needed. Always use the buddy system, this is not a new concept for the fire service but looking out for each others stress reactions may be. Support each other when dealing with those reactions. Give responders time when returned to stations to recover before returning to duty. Provide resilience training, promote debriefing, counseling and a culture of acceptance of feelings in stressful situations.(SAMHSA, 2018, p. 10-11)

To improve behavioral health for first responders, there needs to be a collaborative effort between the leadership and the rank and file of the agency. A system of support that provides adequate training, protection from being overworked and exposed to excessive stress. First responders carry a great burden for the citizens they serve, providing them with the support they need and education to identify the need of that support. Organizations can help reduce these issues through peer support, preventative training on resiliency, and training on interventions on addressing burnout.(SAMHSA, 2018, p. 12)

A resource is available from the New York State Association of Fire Chiefs - Firefighter Behavioral Health: Protecting Our Own was developed as a ready guide for departments looking

for what they should consider for their behavioral health program. The first paragraph, of this guide says “every fire department should have a behavioral health assistance program available to member and their families.” The guide goes on to list that these programs should include peer support, councilors, and chaplain services, education on stress management, traumatic events protocol, screening tools and information about dealing with traumatic events, and access to professional services. When exposed to a traumatic event the recommended protocol would be five steps. Starting with the determination of a potentially traumatic event, timeout or hot wash, trauma screening questionnaire, a complete assessment, and treatment by a specialty clinician. Not all of these steps need to be enacted depending on each situation there is also a flowchart to follow to implement these protocols. The guide recommends an after-action review of every call asking just five questions. 1. What was our mission? 2. What went well? 3. What could have gone better? 4. What might we have done differently? 5. Who needs to know? These simple questions help build resiliency, team cohesion, and gives the ability for company members to assess how each other is doing with the last call.(McEvoy, 2014, p. 1-3)

Law enforcement has taken a different approach to behavioral health, and as mentioned earlier the statistics on suicidal ideation is not as high among police officers as it is with firefighters. Resilience training is just as valuable in the law enforcement community as it is with the fire service. One notable difference is that police officers receive mental health training to deal with those issues on the street giving them the tools to de-escalate incidents involving people with mental health issues. This training gives them the tools needed to identify the signs and symptoms in their fellow officers. (Hoffman, 2017, para. 5-8) This training does not make them immune from mental health issues but may make them better prepared. It is the recommendation of the International Association of Chiefs of Police to have a robust program

with things such as critical incident stress management, fitness for duty evaluation, peer support, and psychological services, suicide prevention, as well as family support and wellness. (The Center for Officer Safety and Wellness [IACP], n.d., Section 2-4)

The US Army has had an identified problem for years with behavioral health. In the beginning, they just grew their programs form 2007 to 2012, over 211 programs were developed throughout the Army causing great inconsistency throughout the service. The system was revamped in 2012 to streamline and allow for standardized training throughout. The programs were standardized and reduced to 11 micro-systems now providing the same care at any installation in the world. (Srinivasan, Ivany, Sarmiento, & Woodson, 2017, para. 2-4) During that same period another step was taken to address behavioral health, placing teams into each unit to assist when needed, where they were needed. The concept of embedded behavioral health was started in Fort Carson in 2009 and has spread across the army putting providers with the units giving soldiers better access to care. The other consequence of the embedding was the reduction of the stigma associated with mental health. Having these teams as part of the unit created an understanding that this was no different than seeing a medical doctor for a sprained ankle. This program has helped keep soldiers mission ready and is helping to keep their lives in better order. (Foss, 2014, para. 2-18)

The last area of consideration to any program is how do we evaluate it, in the Army's case they did a few things they looked at the streamlining of care assuring all soldiers are getting the same treatment all over the world. The reduction of programs from over 211 programs down to just 11. Then they looked at how this care has changed in patient care, showing 66,000 fewer inpatient bed days from 2012 to 2017. Lastly, the adopted the Army's behavioral health data portal, this system allows continuity of care with the soldiers and has them complete surveys

periodically to look for identifying markers for possible developing issues like PTSD or depression. These factors have shown that the program is achieving results. (Vergun, 2018, para. 10-12)

The fire service does not have the resources that the United States Government does to provide behavioral health programs like the Army, but there are ways to assess local department programs. Much like the Army, this can be done in different ways. One way would be to look at employee morale or by doing a cost-benefit analysis of the program. Another would be to look at historical data, has there been a reduction in mental health problems. This approach may be difficult unless you are part of a large metro size department. The most important factor to consider is the evaluation of those members that have used the services. If those members are not satisfied with the program, they will tell others, and it will fail, conversely if they are satisfied more members will be inclined to use the services. (Sherman, 2018, p. 67)

Procedures

To find the understanding and beliefs of the members of the WFD a questionnaire was created and distributed to the 63 operations personnel. It was distributed using the departments training software, Target Solutions and google forms was used to create the questionnaire and track the responses of the members. Using this method allows the researcher to see who did not complete the questionnaire but not know what each individual answered, keeping the results anonymous. 59 members responded giving a rate of 93% return rate giving a good representation of the entire department. It was not expected to gain near a 100% return rate as the WFD currently has a number of members off on long-term injury. The staff personnel were not asked to complete the questionnaire due to them not using the Target Solutions. A sample of this questionnaire can be found in Appendix A, and the results can be found in Appendix B.

In an attempt to find what other departments around the country are doing with regards to mental or behavioral health a questionnaire was sent out to all EFO students that attended courses during March of 2018. All four EFO courses were offered at that time accounting for 87 students in total. Of the 87 questionnaires sent out 40 responses were received, giving only a 46% rate of return, this response was not as good as hoped but did result in a fairly good representation of differently sized departments. This questionnaire was also created using google forms and the responses tracked with that program. A sample of that questionnaire can be found in Appendix C, and the results can be found in Appendix D.

The City of Watertown contracts with a local company named PIVOT to provide EAP services. Their office was visited in search of current services provided to the members of the WFD. The company offers only basic counseling and referral services if continuing appointments are necessary. The councilors do not have any special training to assist emergency responders. The company does conduct some programs for the local area such as alcoholics anonymous even down to less destructive groups such as anglers anonymous.

An informal interview was conducted with Kelly Flanagan-Hall, MS, CEAP, who is the Employee Assistance Program Coordinator for PIVOT, the company that the City of Watertown contracts with for EAP services. The purpose of this conversation was to understand the services provided currently to the members of the WFD and how a supervisor could refer someone to EAP if there were a concern for someone's wellbeing either personally or professionally.

The internet was searched for training opportunities. What are available resources to train staff on subjects of resiliency, sign and symptom identification, and peer support? Programs from law enforcement, the department of defense and the fire service were researched. Private sector coursework was also researched and considered for its relevancy.

Limitations for this research were found to be the lack of responses from the requests made from other departments, although the responses received give a good cross section of departments with varying sizes all represented. The biggest limitation for the implementation of any behavioral/mental health program will be changing the culture of the department. Analyzing the responses of the questionnaire distributed among the WFD it is evident that some members see the value of such a program, but many still do not. As long as this sigma exists, it will be difficult to accomplish having a productive program

Results

The purpose of this research is to identify the components of a mental health program that should be provided by the Watertown Fire Department. This section will explain the findings of the study conducted by reviewing the results of the questionnaire and the findings of the literature review.

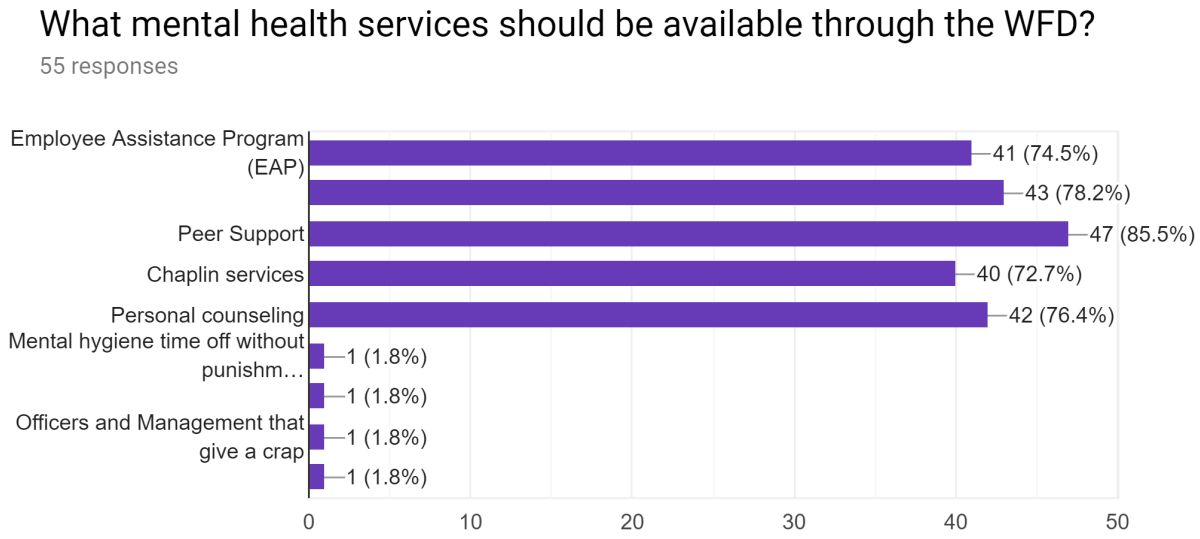
First research question: *What service should or could be offered to members in need of assistance with regards to mental health?* This question was asked directly in the internal questionnaire. The results were varied but all above 72% for the given choices. These results can be seen in Appendix B and the chart below. Peer support recieved the highest level of response at 85.5% Four responses were entered into the other category:

Mental hygiene time off without punishment or having to give info.

EAP with emergency service specific relations. Not some random service.

Officers and Management that give a crap.

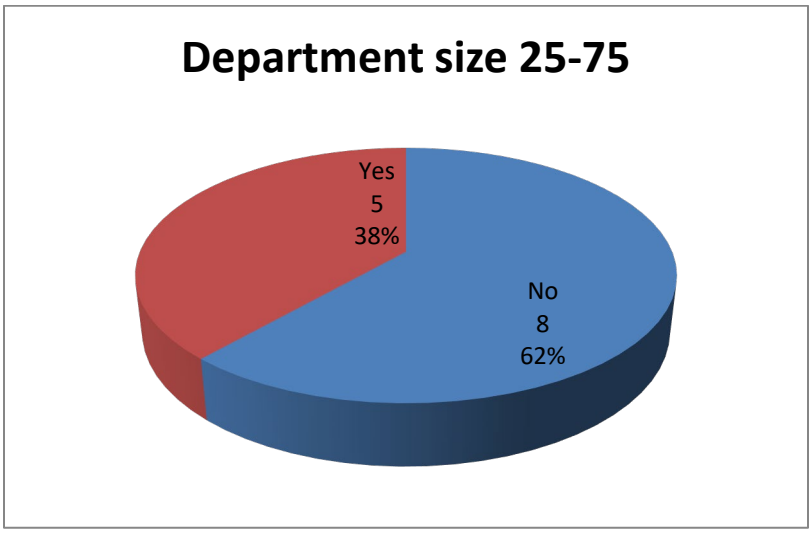
Program through IAFF, A plan for injured firefighters that include sending someone to the hospital with them, fire officer notifying family, transporting family to the hospital etc.

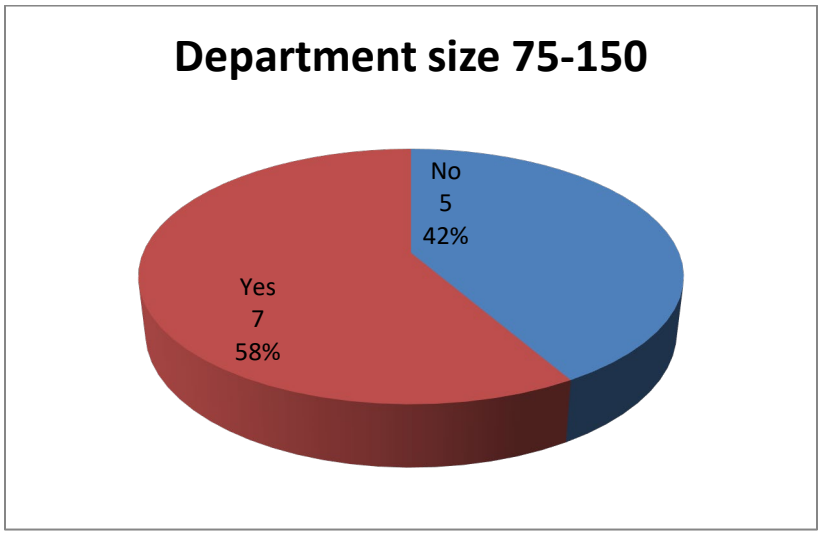


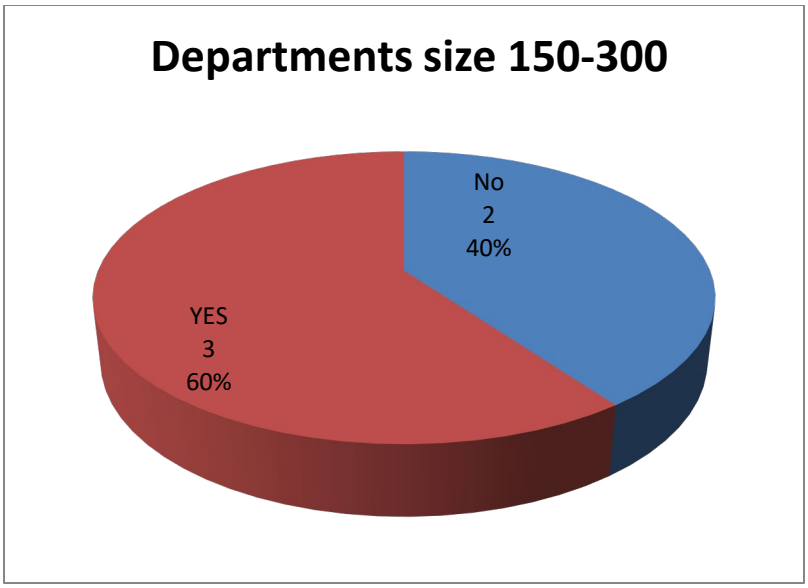
The literature review found similar recommendations, all of the choices listed in the questionnaire supported. EAP, critical incident stress debriefing, peer support, Chaplin service, and personal counseling are all standard components of programs. There were a few other options found in the literature review that were not explored during the questionnaire. Resiliency training was found to a common component with proven results of first responder programs. The law enforcement community IACP recommended fitness for duty evaluations. NFPA recognizes both of these as required components that should be part of all fire department programs. Other training should be looked at along with resiliency, preparing supervisors and coworkers to identify signs and symptoms before they become a problem. Firefighters are trained to handle countless emergencies from technical rescues and fires to hazardous materials incidents and medical emergencies, but most WFD firefighters have almost no training on mental or behavioral health conditions. Why is a firefighter expected to splint a broken arm but if someone was having a mental crisis have no idea how to assist with that. They will be expected to respond to every alarm but do not arm them with the tools to handle the mental health emergency.

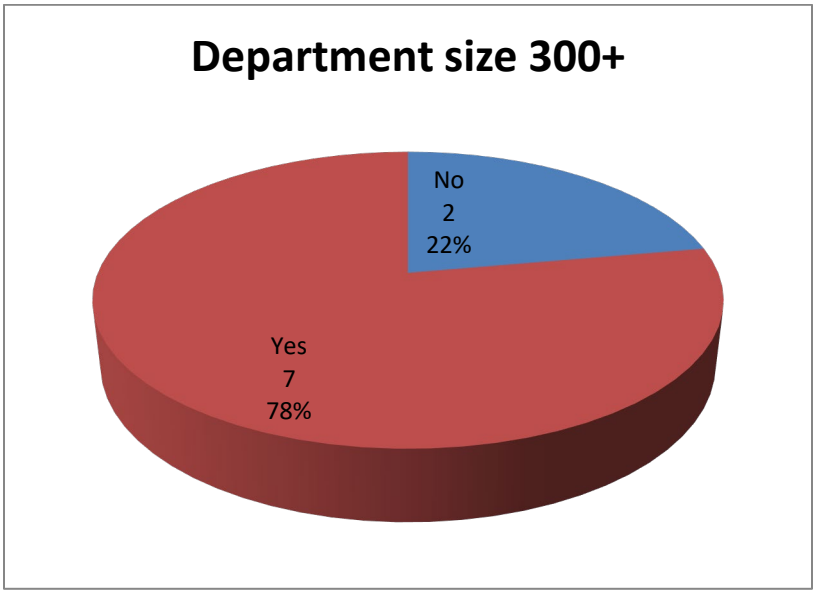
Making them better equipped to handle those alarms will make them better prepared to assist each other in the firehouse and reduce the stigma associated with this condition.

Second research question: *What are the current best practices in the fire service related to mental health programs?* This question has been analyzed by reviewing suggestions from organizations that have previously studied this question and by looking to other departments for what services are provided. The size of departments that responded were first broken down to have an understanding of the percentage of departments that provide a program. The following graphs depict those results.



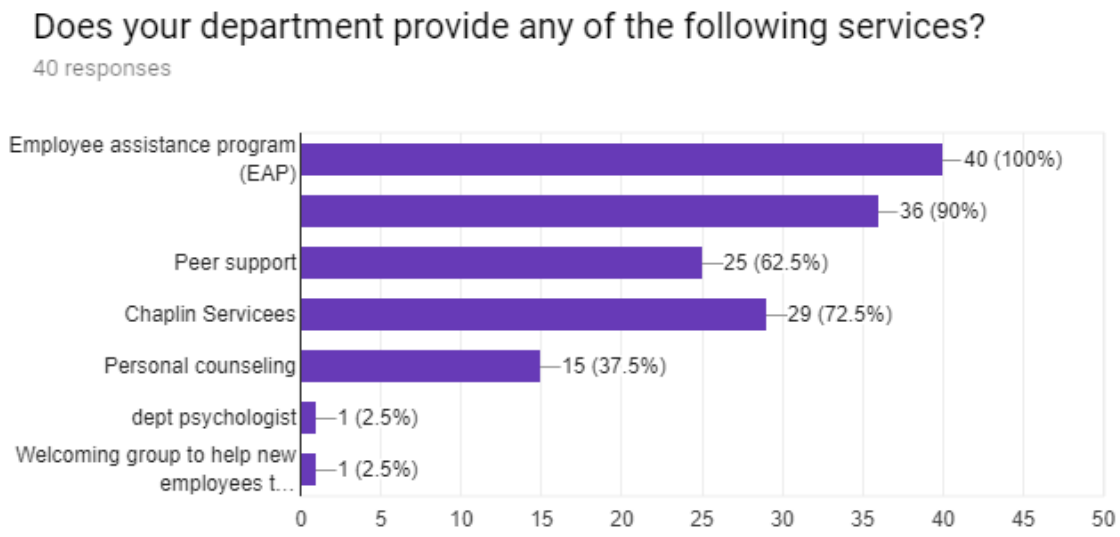






The WFD falls very close the dividing line of this questionnaire this was done intentionally to see if there was a difference between these size departments. It is reasonable to assume that this is a fair representation of departments and from this questionnaire, the larger departments are more likely to offer a program than a smaller department. It does appear that departments with over 75 members are more likely to offer a program than one with less than 75 members.

Reviewing the responses as a whole, 100% of respondents offer EAP services and 90% offer critical incident stress debriefing, then a large drop down to 72.5% for Chaplin services, 62.5% peer support and just 37.5% with personal counseling. One department reported that the city employs a department psychologist that is split between the fire and police departments this professional does ride along, meet with and trains fire department members but does not provide one on one counseling, they do provide referral service to professionals outside of the department. The graph below shows these results and can be found in Appendix D.



The IAFF provides a checklist to asses your department to be a guide in doing a strengths analysis of your current program and see where gaps lie and should be addressed. This checklist can be found in Appendix E. This checklist starts with EAP, peer support, and Chaplin service along with a few others that have been discussed in the literature review.

This overlap does not seem to be a coincidence, EAP is obviously a standard service provided by employers. Many fire departments have a Chaplin, whether they are used as a counselor or not may be the question. Peer support is somewhat of a new concept in the fire

service as a title anyway. Without knowing it, we have all been providing support of each other setting around the firehouse table our entire careers.

Third research question: *What education and training is available to assist with the identification of symptoms and treatment options?* This question was answered by searching the internet looking for options for training and talking to the EAP coordinator for the City service to see what options may be available. The internet search revealed a few options directly related to behavioral health in the fire service the IAFF offers an online course behavioral health awareness, which is a two-hour online course available to IAFF members for free covering subject such as depression, PTSD, substance abuse, etc. The IAFF also offers peer support counseling training, the cost of this course is $7500 for a class size of 30. They do allow the host department to offer enrollment to neighboring departments to fill the class. This course may be funded through the assistance to firefighters grant if your department chooses to and is awarded the grant. (IAFF, n.d.)

The NFFF offers courses as well: 1) Stress First Aid for Firefighters and Emergency Services Personnel and 2) Curbside Manner: Stress First Aid for the Street. Both of these courses are available online or in a classroom setting. The course for first responders is about constant monitoring of our fellow responders and recognizing the effects of that stress and getting that person help. The NFFF also offers an after action review online course this research has shown that performing an after action review is helpful in building resilience, although this course is not directly related to behavioral health it does apply to the overall mental health of crews. (https://www.everyonegoeshome.com/training/action-review-aar/)

The Firefighter Behavioral Health Alliance offers six different workshops with regards to mental health. Savings those who save others is offered in a four hour, two hours and family

edition. This course focuses on suicide prevention/awareness course designed to educate attendees on warning signs/symptoms, communications, emotional and physical behaviors. An internal size up which is a four hour or two-hour course, dedicated to educating attendees on the awareness of stress, anxiety, PTSD, addictions, depression, anger, suicide, and retirement. Saying Goodbye: An emotional detachment is a two-hour course focusing on loss of belonging, loss of identity, and emotion of retiring. Behavioral Health Program Development a two-hour course to assist with creating procedures for a program. Lastly, A Firefighters Life for Medical Professionals and Chaplin's a four-hour workshop to educate about the culture of firefighters and the mentality of being a firefighter. (http://www.ffbha.org/workshops/workshops-offered/)

On a local level, Kelly Flanagan-Hall the EAP coordinator for the City of Watertown's EAP program offered by PIVOT has offered to present an awareness orientation to the department of the services offered and how to access these services to the entire department. She has also offered to allow a few of our members to attend their training on critical incident stress debriefing which is a service there office offers that was not known to the fire department or at least has never been utilized. She also recommended to reach out to Fort Drum Regional Health Planning Organization; they offer a course locally called Mental Health First Aid. This is an eight-hour course aimed at teaching a plan of action when encountering a person with a mental health or substance problem. This course could be offered at the fire station to all members while on duty providing members with information on how to provide better care in the field making them better emergency medical technicians and possibly the ability to recognize signs and symptoms in fellow fire department members.

Discussion

This topic of mental or behavioral health has stepped into the light in recent years whether it was not considered or just not identified looking at the mental wellbeing of our members is a new trend. As the questionnaire of the WFD showed, there is still a stigma about mental health issues. Over 68% have that belief, some even a fear of retribution or humiliation among their peers if they spoke out and asked for help. There has been an EAP program at the WFD since before this author started with the WFD which shows some commitment by the city to our mental wellbeing but after more than 20 years the stigma still stands. This study has found that other programs and services with relation to mental health could or should be offered at the WFD which may have a direct impact on that stigma. Removing the stigma is identified in the behavioral health guide as the role of the leadership. It is the responsibility of the department leaders to change the culture, removing the stigma around mental health issues and creating a belief that mental health issues are not different than a physical health issue.(NFFF, 2017, p. 11-13) This change needs to occur, the suck it up mentality is what is what has brought suicide rates in firefighters to a level that is higher than line of duty deaths. Programs must be developed to train our member to identify signs and symptoms in our brother and sister firefighters and know when we need self-care ourselves. (McGowan & Dutton, 2016, para. 6)

It was found in the questionnaire to others departments, ones that are doing training are mostly concentrating on awareness level training, some offering peer support training which would be a small number of the total membership. Starting right with NFPA education and training from recruit school on into retirement should be offered. Training including depression, PTSD, stress management, and substance abuse to name a few. (NFPA, 2018, p. 58) There were a number of options to begin this training through NFFF, IAFF, and the departments training

software, Target Solutions that can start this training and education process. This training would also assist in changing the culture; the better members understand the problem and signs and symptoms the more conversations will occur and the more accepting the department will become. Peer support training would be a valuable asset within the department. Giving members the ability to speak with someone that they trust, understands where they are coming from, and is available to them on an as-needed basis. These members would know where to direct staff to more qualified councilors that have background with emergency services. (NFFF, 2017, p. 19-20)

Programs can be built in many different ways and some may say what the City of Watertown currently offers is a program. The extent of it is providing an EAP option and counseling 100% paid for by the health insurance. The questionnaire showed that only 17% of the WFD knows that counseling is covered. When the question was asked if you needed help would you know how to access the services available only 50% said yes they would know how. How is it that the City has offered EAP for over 20 years and still 50% of the fire department does not know how to access the service. Along those same lines, only 52% reported that they would feel comfortable accessing EAP. From this research these two components are not enough, programs should include peer support, chaplain services, education programs, screenings, and access to professional services. A policy of after action review should also be implemented answering five simple questions. What was our mission? What went well? What could have gone better? What might have we done differently? Who needs to know? This simple process allows everyone to talk about what just happened and allow everyone on the crew to see where each other are from the call and builds resiliency. (McEvoy, 2014, p. 1-3)

If through the after action review or just conversation someone is identified as having an issue with the event something should be done for that member. The NFFF suggests a protocol for exposure to occupational stress which includes trauma screen questionnaire, a timeout period to collect one's self, or possibly a referral to EAP.(National Fallen Firefighters Foundation [NFFF], 2011, para. 1&2) NFPA directs us to have members evaluated by a physician or mental health professional to assess the member's ability to performs their duties and possible accommodations that should be made. (NFPA, 2018, p. 39)

Without an all-inclusive program of training, education, and services there will no doubt be casualties. The WFD has already seen this over the last 25 years with member and retiree suicides. We as a department must change the culture, remove the stigma, and embrace a new culture where people are not left out to deal with issues on their own.

Recommendations

With a review of what other fire departments offer their members the City of Watertown is in line with what most departments are doing for their members. That does not mean that there is not always room for improvement. As previously stated the WFD offers EAP and both inpatient and outpatient counseling services through the health insurance.

The WFD also has a Chaplin that is an untapped resource, the past Chaplin passed away last year, and a new one was appointed that has been more active with the members and families in need. The last year has been tough for the WFD losing three members and the Chaplin. The new Chaplin has been reaching out to the families of those that have lost their loved ones. This is a new edition that we are seeing with this new Chaplin. He has even responded to some serious alarms to check on everyone’s wellbeing.

Peer support appears to be a new trend in the fire service. This is an avenue that the WFD should try to get some of its members trained. With a stigma within the WFD and an uncomfortable relationship with many members and the EAP providers having peer support from its members would begin to knock down some walls and get more conversations started reducing and hopefully eliminating the stigma. The EAP provider has offered to allow a few of the WFD members to attend their critical incident stress debriefing course in December. This can be the first step in training its members creating a team to help its own.

The most important change that must be undertaken is a change in the culture, removing the stigma and creating an environment of acceptance. This change needs to start with training. Until everyone understands that we can not control our mental health with willpower and that it is in no way a sign of weakness to have an issue, the WFD cannot move forward towards a better tomorrow. Training should start in recruit school and continue throughout everyone's career. This training can start immediately with the course on Target Solutions and those offered through the NFFF. The training office should set up courses like stress first aid and familiarization classes with the EAP provider so members know how to access the program and gain comfort with the providers so they may actually reach out for help if they need it. The WFD should establish a behavioral health committee to organize a functioning program and develop protocols related to behavioral health. Identifying members that will champion this cause and would be willing to get peer support training to offer to the members. The committee should meet with the Chaplin and assess what services he can and will provide to members. The committee should reach out to local mental health professionals to identify those with training or experience with emergency responders and that participate in the WFD insurance plan.

After the completion of this study, it has been identified that the WFD does have some components of a mental health program. There is no designated program, and the culture does not support the idea of making mental health an acceptable subject of conversation at this time. The current leadership does not value mental health programs or at least that is the perception as can be seen from the department questionnaire in Appendix B. With the implementation of a training program and establishment of a behavioral health committee this culture could change and the addition of a peer support team could help the WFD moving into the future.

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Appendix A

Mental Health Programs at the WFD

As part of an applied research project on the topic of mental wellness in the WFD, please complete this questionnaire. This questionnaire is completely anonymous.

How old are you?

21-30
31-40
41-50
51-60
60+

How many years do you have total in the fire service?

5-10
11-15
16-20
21-25
26-30
31-35
36-40

Do you think the WFD does enough with regards to mental health?

Yes
No

What mental health services do you believe are available through the WFD?

Employee Assistance Program (EAP)

Critical Incident Stress Debriefing

Peer Support

Chaplin services

Personal counseling

Don't Know

What mental health services should be available through the WFD?

Employee Assistance Program (EAP)

Critical Incident Stress Debriefing

Peer Support

Chaplin services

Personal counseling

Other:

Would you know how to access any programs available to you if you needed to?

Yes

No

Do you think there is a cost to you to access any programs available to you?

Yes

No

I don't know

Can you access these programs anonymously?

Yes

No

I don't know

Other:

Would you feel comfortable accessing the Employee Assistance Program?

Yes

No

Would you be more likely to access the program if peer councilors were available within the department?

Yes

No

Maybe

Do you think Post Traumatic Stress Disorder (PTSD) is an issue in the fire service?

Yes
No

Do you believe that there is a stigma in the WFD if a member felt the need to seek treatment for workplace or off duty stress?

Yes
No

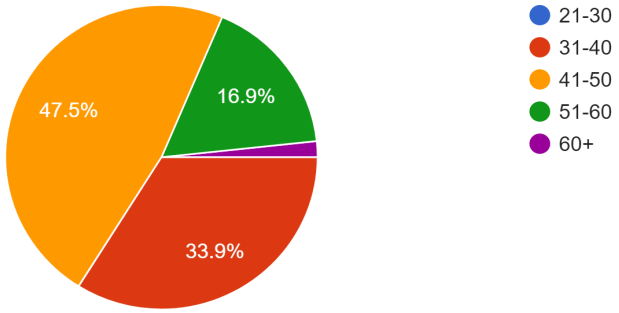
Do you think there is more that could be done by the WFD to make mental health a more acceptable topic? If so what?

Your answer

Appendix B

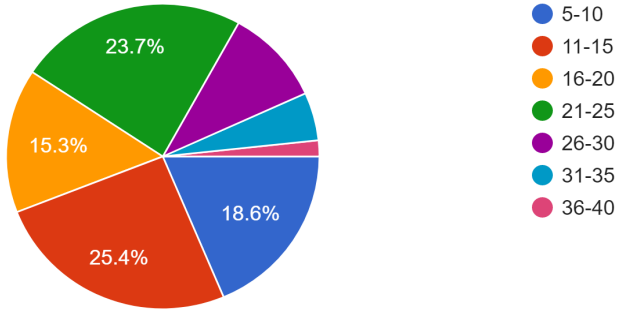
How old are you?

59 responses



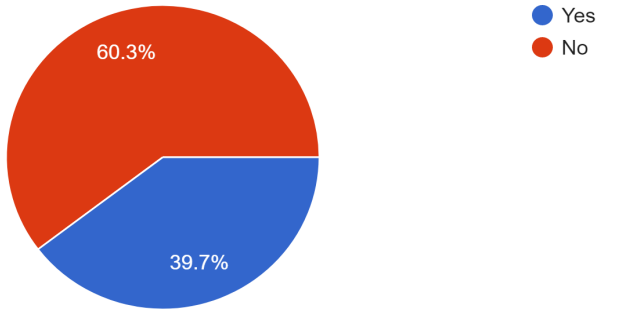
How many years do you have total in the fire service?

59 responses



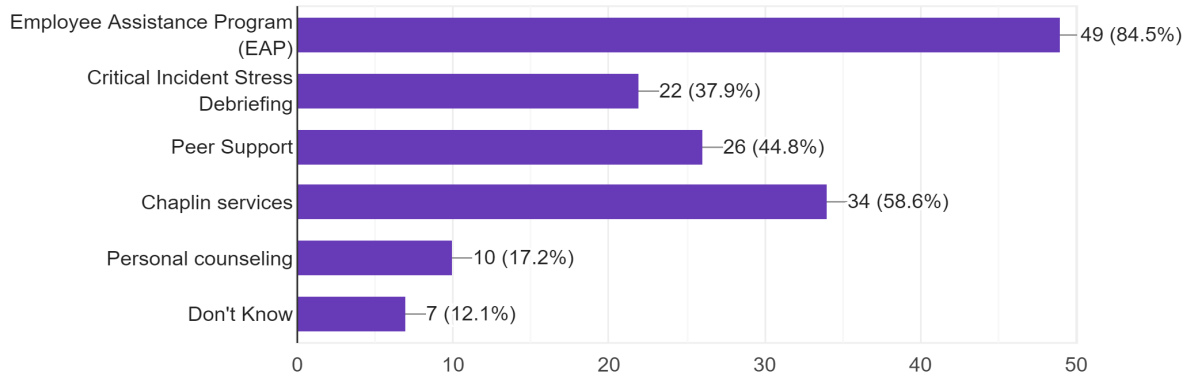
Do you think the WFD does enough with regards to mental health?

58 responses



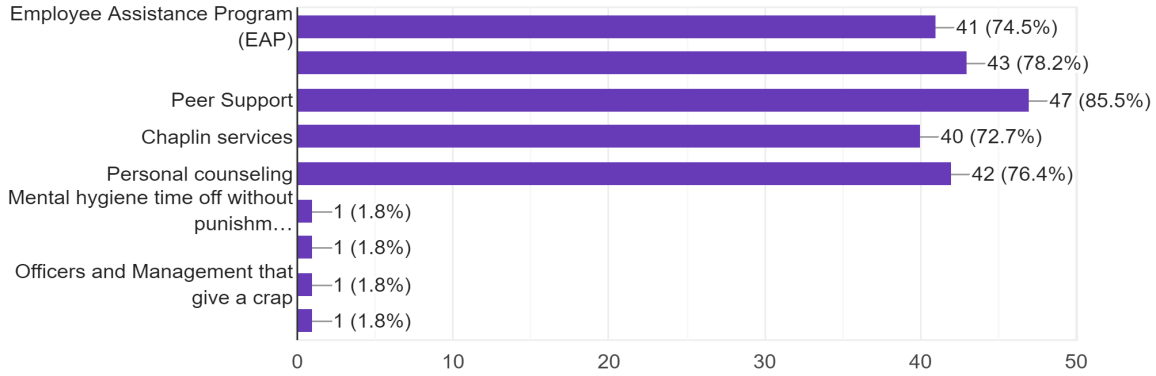
What mental health services do you believe are available through the WFD?

58 responses



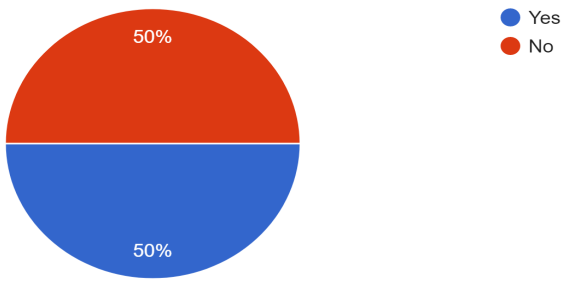
What mental health services should be available through the WFD?

55 responses



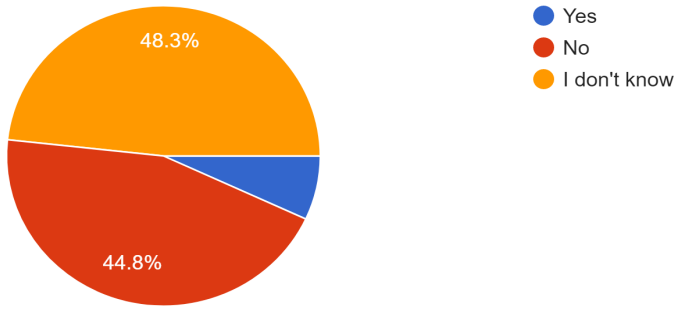
Would you know how to access any programs available to you if you needed to?

58 responses



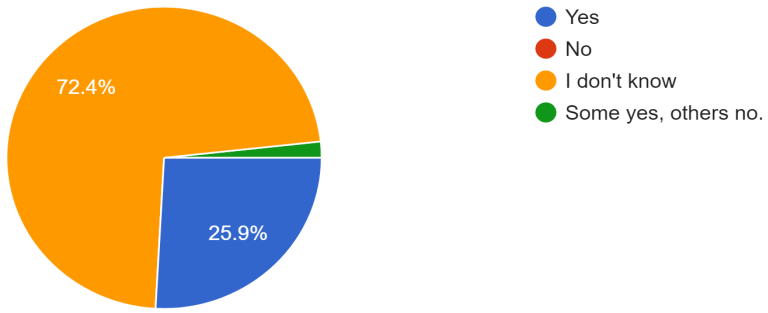
Do you think there is a cost to you to access any programs available to you?

58 responses



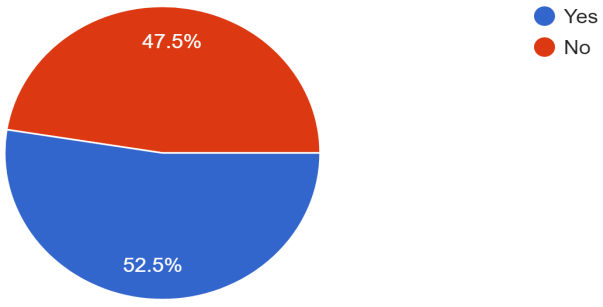
Can you access these programs anonymously?

58 responses



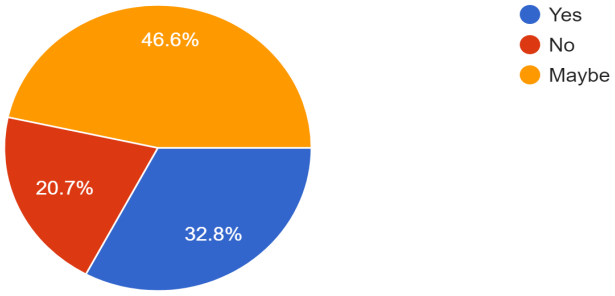
Would you feel comfortable accessing the Employee Assistance Program?

59 responses



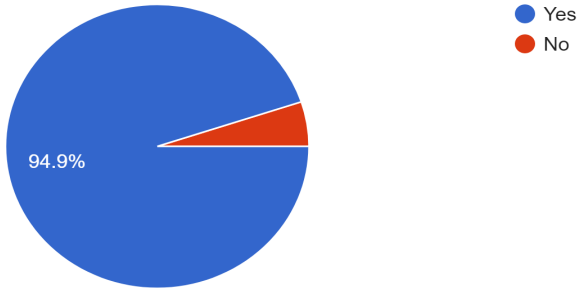
Would you be more likely to access the program if peer councilors were available within the department?

58 responses



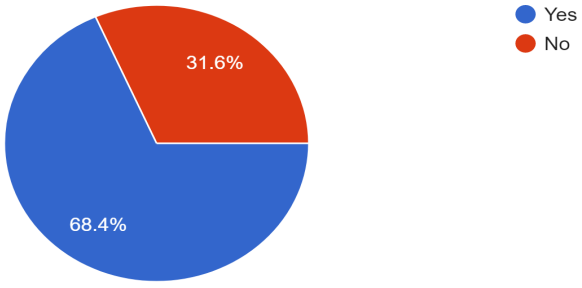
Do you think Post Traumatic Stress Disorder (PTSD) is an issue in the fire service?

59 responses



Do you believe that there is a stigma in the WFD if a member felt the need to seek treatment for workplace or off duty stress?

57 responses



Do you think there is more that could be done by the WFD to make mental health a more acceptable topic? If so what?

1	not sure everyone fears reprimand or humiliation
2	The chiefs need to recognize there is a problem before anything will be done. They continue to bury their heads in the sand and make things worse. Many members are suffering and management refuses to recognize the problem. I know several members that have had to seek out counseling on their own after incidents, on their own time, through their own resources to deal with incidents that occurred at WFD. This is unacceptable as these resources should have been made available by management.
3	The first issue is the member has to admit that they have a problem and need help. Without defining the problem, it is difficult to find a solution
4	no
5	All members should have the Chaplins contact information.
6	talk about it more often and make it known its a REAL ISSUE in our career field.
7	I think our administration should stop adding stress to our employees. External stress (City Hall hates us) is much easier to deal with than stress from your supervisors.
8	Some how show guys that it is ok to be bothered by things. Perhaps show examples from experienced firefighters that are real and not just some scripted video.
9	Break the stigma and talk more about.
10	We fail to take seriously and respond proactively to the accumulative effect of this career. Help is available through EAP and insurance covers counseling. This is in spite of our failure to educate members, promote health and encourage positive attitudes in regards to mental health and safety in general.
11	Yes, accept it is normal to have issues and embrace a culture accordingly

12 not sure

13 Mental health becoming an acceptable topic to discuss within the WFD is an adopted culture by its members. A Culture of mental health can be better accepted within our department when the department Chiefs recognize the importance of member awareness on this topic and check their ego at the door of the station.
Skip

14 stress debriefing after certain calls

15 Address it. Management needs to focus on things that matter instead of small, petty things.

16 When the stressor is another member, little can be done. Some members continually point fingers, place blame and pass judgement on others.

17 no

18 Improve morale

19 be proactive and create a policy that is accepted by the members and trained on annually to ensure complete understanding and to allow for input for changes

20 Yes

21 Greater peer support and more frequent discussion

22 More programs and discussions about mental illness

23 no

24 yes

Appendix C

Mental Health in your department

What is the size of your department?

- Less than 25
- 25-75
- 75-150
- 150-300
- 300+

Does your department have a mental/behavioral health program?

- Yes
- No

If you have a program please give a brief description.

Your answer

Does your department provide any of the following services?

- Employee assistance program (EAP)
- Critical Incident Stress debriefing
- Peer support
- Chaplin Services
- Personal counseling
- Other:

Do you offer any training to your members in identifying mental health concerns? PTSD, depression, etc.

- Yes

No

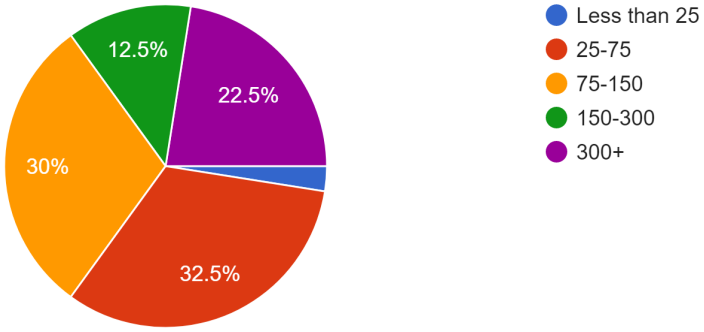
If you offer training what does that entail?

Your answer

Appendix D

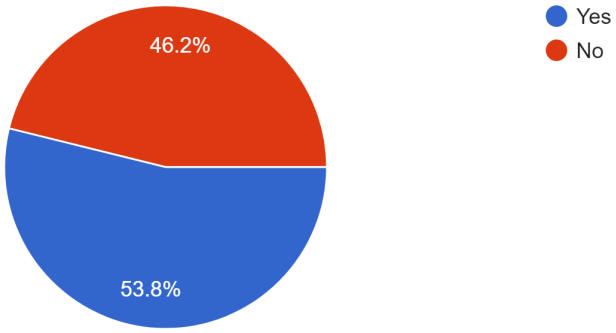
What is the size of your department?

40 responses



Does your department have a mental/behavioral health program?

39 responses



If you have a program please give a brief description.

An in-house peer support group, and FF training on mental health

Chaplains program and CISM for know ready to add peer support

We have a psychologist embedded with the fire and police departments. The two departments share the cost of his salary, and he spends equal hours with each department doing ride-alongs, visiting with the members, teaching classes, and providing support. He does not do counseling for our members per his contract - he does, however, have an extensive list of professionals that he can refer to.
We also have a peer support group with four members per shift.

EAP Services

EAP with a local private organization. We are looking into starting our own peer support although all the research says don't work with your own personnel.

Peer guidance

We have a multifaceted program covering CISM, defusing, debriefing, Chaplin services, EAP, and peer support.

The services listed below which falls under Health and Safety Chief.

We offer CISM personnel after an incident. Cooperation is voluntary and not many (if any) participate

Peer support team

Peer Couseling, EAP and contract mental health services

We have a Staff psychologist and family counselor

It is a comprehensive behavioral health program with elements such as Chaplaincy, EAP, Peer Support, CISM, Mindfulness, Union Support, Administrative Support, and Training

Case by case, but counselors provided for those requesting and/or demonstrating need.

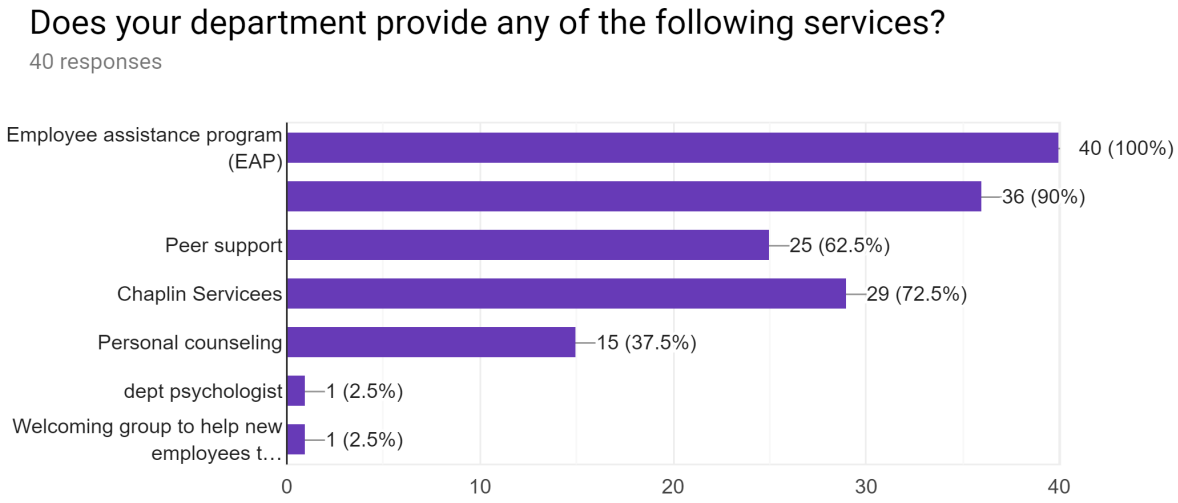
EAP and Chaplin programs

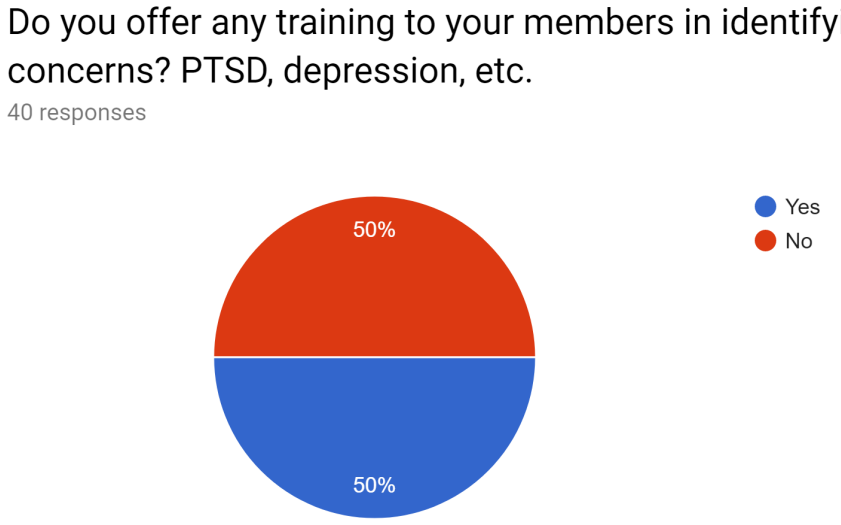
We have a peer support team, we have a contract with a doctor who provides an annual presentation and we have access to her in a one on one setting.

Employee Assistance Program and CISM.

Private 3rd party counseling EAP

Peer counseling, referral program should psychology issues need addressing.





If you offer training what does that entail?

Classes taught by Tennessee Fire and Codes Academy and classes from the Tennessee Federation of Fire Chaplains

Peer support training, training for mental health awareness

Awareness class in recruit classes

mostly awareness and how to identify someone in 'pre-crisis'

One on one counseling sessions with a licensed provider.

I did my EFO paper (year 1) on mental health awareness. After completing the paper I developed an Awareness class and delivered it to all 4 groups (approximately 150-160 people).

Minimal awareness level, Department efforts are grossly minimal

We send employees to CISM training and allow them to begin the process as soon as possible after incidents. They are also key in supporting members during formal debriefings.

Online class, ability to attend conferences

Awareness level only with avenues for follow up.

Annual review of mental health services provided. Awareness of common mental health conditions, how to approach a friend/co-worker who may those conditions, how to get help.

Online, PowerPoint, and classroom

Video based and classroom based annual training

We have had trainings with members and their spouses to discuss ways to recognize mental/behavioral health issues and avenues for getting help.

Table top discussion & videos explaining importance of mental health concerns.

Excited Delirium training and such.

Annual training to company officers on signs/symptoms of PTSD.

Appendix E

Building a Comprehensive Behavioral Health Program

CHECKLIST

Use the following checklist to determine current strengths and gaps of your current behavioral health program. Record next steps on Action Planning template on the back of this form.

Program Components	Utilized	Not Utilized	Not in Place	Next Steps
Employee Assistance Program				
Member Assistance Program				
Behavioral Health Standing Committee				
Behavioral Health Specialist				
Peer Support Program				
Family Services/ Outreach				
Retiree Services/ Outreach				
Chaplain				

Program Referrals	In place	List Not vetted	Not in Place	Next Steps
List of vetted outpatient clinicians/ talk therapists				
List of vetted outpatient psychiatrists/ prescribers				
List of vetted inpatient treatment center(s)				
List of vetted 12-step meetings or support groups				

Critical Questions	Yes	In progress	No	Next Steps
Do you survey your members to determine member awareness and utilization of current behavioral health services?				
Does your department or union have funding allocated to behavioral health or member services?				
Do you currently offer periodic behavioral health education to both members, recruits, and retirees?				
Do you conduct annual medicals which include a behavioral health evaluation or screening?				
Do you have a process in place to deploy post-incident peer response?				
Do member insurance plans cover bother mental health and substance abuse treatment services?				
Are there SOPS in place for behavioral health issues?				

Last Updated 4/3/18

Building a Comprehensive Behavioral Health Program

ACTION PLANNING

Building a comprehensive behavioral health program requires systematic planning leadership and teamwork. Use the table below to record next steps identified on page 1. Then, identify **WHY** this step is important, **WHO** is best to take the lead, and **WHEN** this step should occur:

Next Step	Why is this important?	Who will take the lead?	Target Date

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