Strategies to Improve Firefighter Mental Health Awareness in the Dayton Fire Department

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Certification Statement

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Signed: 

Abstract

In 2019, the Dayton Fire Department (DFD) experienced multiple tragedies that negatively impacted its employees. Among the most notable were an F4 tornado that caused significant damage throughout the city, a mass shooting that left ten dead, a double fatality vehicle accident involving children known to DFD employees, and the suicide of a beloved firefighter. The problem was the DFD had not determined an impactful way to improve firefighter mental health awareness. The purpose of this research was to identify effective strategies that would allow the DFD to improve firefighter mental health awareness. The descriptive research method was used to determine what other fire departments had done to address firefighter mental health awareness in their department in addition to identifying the stressors that were contributing factors to post-traumatic stress for first responders. The research also sought to identify the barriers that were preventing the DFD from having a more substantial impact on firefighter mental awareness. Multiple research methods were used to answer these questions, including a survey of DFD members and first responders across the country that have been impacted by repeated exposure to traumatic events as well as interviews with subject matter experts. The results showed that while some departments have found success through the use of peer support programs, most relied heavily on employee assistance programs and critical incident stress debriefings to address their mental health needs. Respondents identified sleep deprivation and the stigma associated with asking for help as the principle barriers preventing the DFD from having more impact on firefighter mental awareness. The recommendations included a Behavioral Health Program for department members to improve employee wellness, a training program to help members recognize PTSD symptoms, annual mental health checkups, and increased funding and support to include a physician liaison for the department's peer support team.

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Introduction

On August 27, 2019, a stabbing suspect stole a police cruiser and crashed it into a minivan full of children while traveling nearly 100 mph. Dayton firefighters quickly responded to the scene and provided emergency care to the injured, but tragically, two six-year-old girls were killed. After returning to quarters, one of the responding firefighters texted his wife an ominous message, stating, "I can't do this anymore." Less than two months later, the firefighter hanged himself in his home, rendering the Dayton Fire Department but another contributing department to the nation's burgeoning firefighter suicide rate.

The problem is the Dayton Fire Department (DFD) has not determined an impactful way to improve firefighter mental health awareness. The purpose of this research is to identify an effective strategy that will allow the DFD to improve firefighter mental health awareness. The descriptive research method will be used to answer the following research questions: a) What have other fire departments done to address firefighter mental health awareness in their department? b) What mental health stressors have emergency service providers identified as contributing factors to post-traumatic stress? c) What barriers are present that are preventing the Dayton Fire Department from having a more substantial impact on firefighter mental awareness?

Background and Significance

The City of Dayton is the sixth-largest city in the state of Ohio, covering approximately 56 square miles. Affectionately known as the "Gem City," Dayton is nestled nearly equidistant between the State's capital of Columbus and the City of Cincinnati and is recognized as the county seat of Montgomery County. According to the most recent census, 141,527 people call Dayton home (United States Census Bureau, 2017). Dayton's rich patent and invention history include contributions by Orville and Wilbur Wright, who became the first to pilot a powered

plane in 1903 and Charles Kettering, who invented the electric self-starter and electric lights for automobiles (Ohio History Central, n.d.).

Established in 1863, the Dayton Fire Department (DFD) is a career fire and emergency medical services organization consisting of 344 members that operate 12 firehouses in a three-platoon system. The Emergency Services Division maintains minimum staffing of seven engine companies, four ladder companies, and seven advanced life support (ALS) medic units that in 2019 responded to more than 39,000 incidents. Each fire suppression apparatus is staffed with four uniformed personnel, and each can provide ALS care to the sick and injured. The department cross-staffs several specialized pieces of equipment and apparatus, including a type one Regional Hazmat unit, two heavy rescue units, two rescue boats, and two air supply trucks providing high-angle, confined space, auto extrication, and swift water rescue capabilities.

The Strategic Programs and Safety Division coordinates department programs and services that include training, emergency planning, health and safety, technology, and domestic preparedness while the Support Services and Resource Management Division (SSRM) ensures continuous operational readiness by providing a system of efficient services for apparatus, equipment, supplies, facilities, and community services. Both divisions are managed by an assistant chief and strive to meet the high demands required of a modern metropolitan fire service organization.

Highly valued by the citizens of Dayton, the DFD routinely receives the highest customer satisfaction ratings among all other city departments due in part to its ability to provide an effective safety net of fire, EMS, hazmat, and technical rescue services that saves lives, and protects property. The DFD has an annual budget of 43 Million dollars and averages just over 4.5 million dollars of fire loss each year. In 2016, the DFD earned a Class 2 Public Protection

Classification rating from the Insurance Services Office, Inc. (ISO), placing Dayton in the top two percent of communities nationally for fire suppression capabilities (Lykins, 2018, p. 7).

Like many fire departments, the DFD has very little historical records from its inception. While the department has chronicled those who have lost their lives in the line of duty as far back as 1887, it has no record of past members who perished by their own hand. The lack of historical data regarding firefighter suicide may not be unique to Dayton as exhaustive online searches returned no results for any department between 1850-1950. The absence of reportable data may be attributed to the generally poor record-keeping of some departments, but one can only wonder if past generations of firefighters also regarded such information as far too secretive about sharing with others.

Presently, firefighter suicide is a painfully familiar subject to the Dayton Fire Department. Three well-respected members have committed suicide within the last 17 years, with two of those suicides occurring over the last five years. This does not include the many resigned and retired members who have died during the last five years whose deaths where substance abuse was likely a contributing factor. Fortunately, such data has become increasingly available as organizations across the nation have begun to appreciate the value of and benefit from sharing information about firefighter suicide.

The Ruderman White Paper on Mental Health and Suicide of Fire Responders reports that firefighters are more likely to die by suicide than in the line of duty (Heyman, Dill, & Douglas, 2018). While the paper focused on suicides and line of duty deaths that occurred in 2017, more firefighters died by suicide than the line of duty in 2018 and to date in 2019, the number of firefighter suicides more than doubles the current number of line of duty fatalities (“Firefighter deaths,” 2019). This unfortunate and unacceptable trend predicts an alarming

probable future impact for the Dayton Fire Department and every other emergency service organization in the United States. The increasing rate at which firefighters are dying due to suicide will likely continue unless an effort is made to address the underlying behavioral health issues facing those who are sworn to protect and serve.

Established in 1896, the National Fire Protection Agency (NFPA) serves as the leading resource "devoted to eliminating death, injury, property and economic loss due to fire" ("NFPA Overview," n.d., para. 1). The self-funded, non-profit organization also provides information and knowledge on fire, electrical, and related hazards. Widely recognized as the national agency responsible for collecting statistical data on firefighter deaths and injuries, it focuses comparatively little attention to members lost to suicide, even though firefighter suicides have outpaced firefighter line of duty deaths during the last six years.

Jeff Dill, the founder of the Firefighter Behavioral Health Alliance (FBHA), has tracked and verified all self-reported firefighter suicides for the last two decades. Initially providing counseling services for firefighters, Dill established the FBHA in 2011 to help firefighters, EMS personnel, and their families respond to the effects of PTSD, depression, addiction, and suicide ("Firefighter Suicide Statistics," 2019). The non-profit organization's goal is to improve the mental health awareness of first responders while significantly reducing the number of suicides at the hands of firefighter and EMS personnel ("Firefighter Behavioral Health Alliance," 2019).

Figure 1 highlights the alarming trend of firefighter suicide outpacing line of duty deaths during the last six years. For many of those years, the firefighter suicide rate doubled that of line of duty deaths. The FBHA suggests that its suicide numbers may be 45-50% less than what is shown below, as nearly half of all suicides go unreported ("Firefighter Suicide Statistics," 2019). The red bar graph in Figure 1 represents all firefighter suicides, including those that are self-

reported and verified and those that are estimated to be unreported. The staggering loss of life found in that metric underscores the urgent need for improved mental health awareness for the country's first responders and suggests that the American fire service must be more attentive to the mental health needs of those who protect and serve.

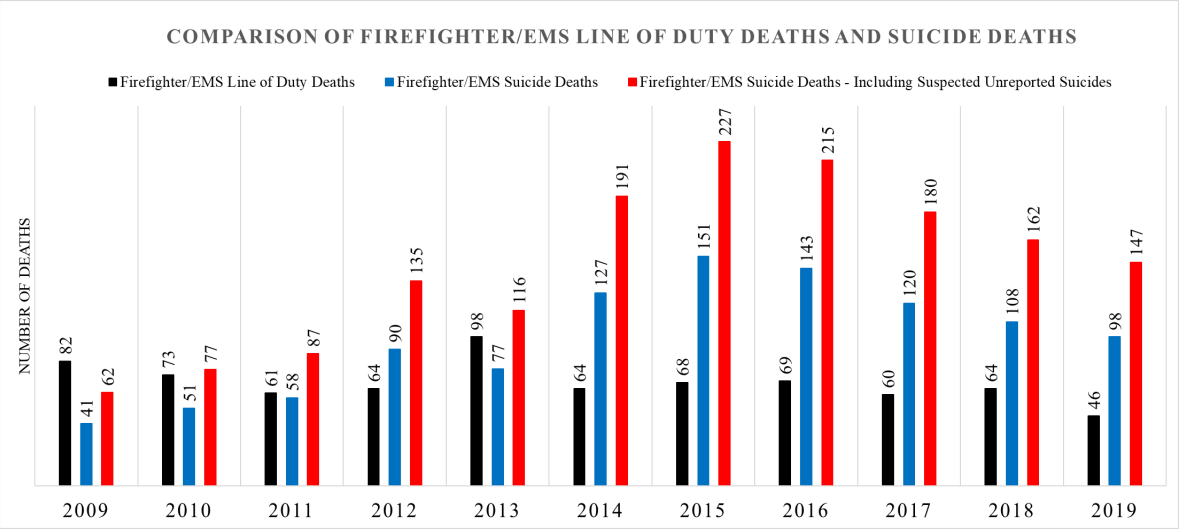

Figure 1. Firefighter line of duty and suicide death comparison 2009-2019.

There is no question that more accurate data is needed to fully appreciate the scope and scale of the behavioral health problem facing the fire service. Fortunately, legislation currently in congress may provide a solution to address both the lack of accurate suicide reporting and the lack of occupation-specific interventions to reduce the suicide incidence in public safety providers. Introduced in March 8, 2019, the "Hero Act of 2019" or "Helping Emergency Responders Overcome Act of 2019" would require the Secretary of Human Services to "improve the detection, prevention, and treatment of mental health issues among public safety officers" ("Hero Act of 2019," 2019, para. 1). The House of Representatives Bill 1646 (H.R. 1646) would also require that the Director of the Center for Disease Control and Prevention create and maintain the Public Safety Officer Suicide Reporting System so that public safety officer suicide

data could be collected to facilitate the study of appropriate interventions ("Hero Act of 2019," 2019).

While law enforcement and the military service professions have benefited from the many large-scale funded research efforts regarding suicide risk, firefighting remains an understudied profession. In 2008, the National Fallen Firefighters Foundation (NFFF) adopted a consensus approach to help fill the void of research on firefighter wellness. The NFFF collaboratively worked with the International Association of Firefighters (IAFF), International Association of Fire Chiefs (IAFC), NFPA, Employee Assistance Professionals (EAP), and behavioral health professionals to identify new approaches and resources to help firefighters better manage the emotional and physiological stress commonly experienced.

As part of its "Everyone Goes Home" campaign, the NFFF has identified 16 life safety initiatives designed to prevent injuries and line of duty deaths. Initiative 13 addresses the need for psychological support and suggests that discussing every call at the "back step" or kitchen table may be the first chance to observe stress in firefighters and EMS personnel ("Everyone Goes Home," n.d.). Despite this vaulted effort, the NFFF acknowledges that it is currently uncertain how to adequately provide psychological support to first responders as "research has raised significant concerns about intervention and treatment approaches that have been and are to this day commonly used with fire service personnel" ("Everyone Goes Home," n.d., para. 2).

There is an ineffaceable link between the complex problem of identifying impactful ways to improve firefighter mental health awareness and the content of the Executive Fire Officer Program's Executive Analysis of Fire Service Operations in Emergency Management (EAFSOEM) course. The primary focus of the EAFSOEM course is to teach the Executive Fire Officer (EFO) the knowledge and skills needed to analyze fire service operations in emergency

management so that they are better able to protect their communities from various disasters. Response to these large-scale events often exposes personnel to the unprecedented destruction and loss of life that may ultimately lead to post-traumatic stress disorder (PTSD), depression, and in some cases, suicide.

There is an established link between the problem of firefighter mental health awareness and the United States Fire Administration (USFA). Managed by the Federal Emergency Management Agency (FEMA) of the Department of Homeland Security (DHS), the USFA has embraced an approach to emergency management that includes all hazards. The organization recently updated its mission statement to "a prepared and resilient fire and Emergency Medical Services" and solidifies its commitment to the problem by including health and wellness in two of its three strategic goals (U.S. Fire Administration, 2019, p. 1).

The USFA's first goal is to "build a culture of preparedness in the fire and emergency medical services" to help fire and EMS organizations with increasing their organizational resilience (U.S. Fire Administration, 2019, p. 1). The second USFA goal is to ensure that the nation's EMS and fire services are ready for all hazards. One of the objectives the USFA will strive for to meet this goal is by "strengthening the culture of health and wellness to improve responder safety and survival" (U.S. Fire Administration, 2019, p. 1). This clear commitment by the USFA to focus on improving both employee wellness and organizational resilience highlights the appropriateness of continued research on firefighter mental health awareness.

Literature Review

A comprehensive literature review was conducted to delve into and recapitulate the findings of others who have published research related to firefighter mental health awareness and firefighter suicide. The extensive study began on October 7, 2019, at the Learning Resource

Center (LRC) located on the campus of the National Fire Academy (NFA) in Emmitsburg, Maryland. The primary sources reviewed at the LRC included journals, magazines, and applied research proposals (ARP) conducted by Executive Fire Officer (EFO) candidates. Multiple academic search engines, including Google Scholar, Microsoft Academic, Bielefeld Academic Search Engine (BASE), and Semantic Scholar, were used and focused on the keywords "firefighter mental health," "firefighter suicide," "firefighter resiliency," and "suicide." Since firefighter mental health and firefighter suicide appear more often in contemporary publications, the "Google" search engine was also widely used.

Suicide has been defined as the act or instance of taking one's life voluntarily and intentionally ("Suicide Definition," n.d.). "Died by suicide" is the preferred term, as some feel that the term "committed suicide" implies that a person who takes his or her life has committed a crime. Relatedly, the term "suicidality" is used to reference those who have serious thoughts about killing themselves (ideation), those who have created an actual suicide plan, and those who have experienced non-fatal suicide attempts. The distinction between suicide and suicidality is important because while honoring the dead is a noble pursuit, it does little to prevent future suicides. As such, the mental health awareness aspect of this research resides in developing a better understanding of firefighter suicidality so that early warning signs can be identified, and prevention strategies can be implemented.

Suicide is the second leading cause of death for people between the ages of 10 and 34. For individuals between the ages of 35 and 54, suicide is the fourth leading cause of death ("National Institute of Mental Health," 2017). Additionally, the suicide rate among males is four times higher than among females, placing the typical American firefighter squarely in the "at-risk" demographic. Exacerbating the risk of suicide for first responders is the increasing evidence

that the heightened levels of post-traumatic stress symptoms (PTSS) commonly associated with firefighting and EMS professions are indelibly linked to increased incidences of suicide ideation (SI) and suicide attempts (Boffa et al., 2016).

Henderson et al., (2016) agree that the suicide risk for firefighters is greater than the civilian populace due in part to the "disturbingly higher rates of posttraumatic stress disorder and substance abuse disorders" but also posit that such disorders can serve as markers, or predictors for suicide completion. These markers lie at the very heart of most mental health awareness programs and serve as a starting point to identify those who may be experiencing a personal crisis. Once those markers have been identified, the focus of most fire department behavioral health providers is to ensure that mental health awareness, education, and other resources are readily available to provide the necessary support and guidance.

The PTSD markers that may serve to identify those at risk for SI or suicide attempts vary among individuals concerning physical symptoms. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) focuses instead on behavioral symptoms as identified among the following diagnostic clusters:

- Re-experiencing-Flashbacks, nightmares, or emotional/physical distress to reminders;
- Avoidance-Avoiding memories or reminders of the event;
- Negative Connotations and Mood-Inability to recall the event, blaming oneself, isolation;
- Arousal-Self-destructive behavior, irritability, and aggression (American Psychiatric Association, 2013)

The lack of behavioral health programs and cultural lack of mental health awareness within the fire service have been identified as critical shortcomings for effective employee care. "Many providers are left to deal with the chronic stress on their own, either because of a lack of

effective employer-based programs or a culture that discourages its use (Boldt, 2016, p. 3). While mental health awareness has only recently broached the fire service, some progressive, forward-leaning departments have made great strides with improving the mental health awareness of their members as a means to improve the identification, prevention, and treatment of posttraumatic stress.

The Houston (Texas) Fire Department (HFD) places emphasis on employee emotional safety and well-being during its academy training for its newest cadets ("HFD Mental Health Services," 2019). In concert with the department's psychologist, chaplain, and other key partners, the organization strives to reduce the stigma of having psychological difficulties by creating an environment where referring a co-worker for help is viewing as "assisting" instead of the well-versed "snitching" mentality found in other departments ("HFD Mental Health Services," 2019). The commitment to suicide prevention and mental health awareness extends throughout the organization and includes retired members as well as their families ("HFD Mental Health Services," 2019).

Like many fire departments across the country, Dallas Fire-Rescue once routed substance abuse, PTSD, and mental health issues through its employee assistance program (EAP). Driven in part by the suicide death of one of its members, in 2018, the department contracted with various mental health providers to provide treatment. Posters were placed in every firehouse that includes the telephone number and QR code that links directly to a 24-hour mental health hotline. DFR Chief David Coatney acknowledged the need to help those within the organization who were suffering from substance abuse and PTSD as a result of job stress and suggests that the department would continually "tweak and improve" the program to address the needs of its members (Highberger, 2018).

Despite an initial lack of support from city officials who failed to see a return on investment for behavioral health care, the Indianapolis Fire Department (IFD) has created a peer support team that goes beyond providing aid in the form of critical incident stress debriefings (CISD) after critical events (Bavis, 2018). The team also visits fire station personnel to create relationships that help to remove the stigma of asking for help from others. The department has also created a partnership with the Indy Public Safety Foundation (IPSF) to provide mental and behavioral health services to all Indianapolis safety forces personnel free of charge (Bavis, 2018).

Across the country, many fire departments like the ones discussed above have realized the importance of addressing employee mental health. The literature review finds the majority of departments that have begun to focus attention and resources towards behavioral health do so through the use of a combination of EAP, critical incident stress debriefings (CISD), peer support, and partnerships with outside agencies capable of providing mental health services. The focus shared by most departments includes identifying the effects of PTSD and minimizing the consequences.

The research shows, however, that this approach may not be enough.
Boffa et al., (2018) examined the risk of suicide among male firefighters and found that anxious sensitivity (AS) cognitive concerns may provide a treatment opportunity to reduce PTSD and suicidality (Boffa et al., 2018). Defined as an exaggerated fear of potential consequences or a fear of anxiety itself, AS can manifest as physical symptoms such as upset stomach and sweating and serve as a portent of death to those already struggling with PTSD and suicide ideations (Boffa et al., 2018). Continued research that identifies modifiable risk factors in at-risk employees may ultimately serve to sever the link between PTSD, SI, and future suicide attempts.

Spoons (2018) evaluated the effectiveness of mental health assistance programs at a suburban Chicago fire department. The mixed-method study specifically examined the efficacy of CISD and Employee Assistance Programs (EAP) to determine if they provided adequate stress management and suicide prevention strategies. The study found that despite wide-spread use, the overall effectiveness was limited to only 4.8% of the nearly 30% of employees who had experienced EAP and CISD programs (Spoons, 2018). While limited to a small survey sample, this study implies that a gap exists between the mental health needs of the department studied and the services that are provided to meet those needs.

The nexus between what emergency responders need to prevent and manage PTSD effectively and what mental health professionals can provide may be attributed to the lack of contemporary research and the lingering stigma that many firefighters feel when asking for help. Henderson et al., (2016) posited that firefighters often demonstrate an us-verses-them mentality when it comes to mental health professionals from outside of their organization and that such self-isolation may limit the practitioner's ability to provide meaningful treatment. The study also identified the need for fire department culture to evolve from viewing stress management as a potential sign of weakness and instead as part of a normal response to very atypical events (Henderson et al., 2016).

An evaluation of the current literature reviewed exposes a limited but growing body of evidence that firefighters are at an increased risk of SI and suicide attempts due in part to exceedingly high rates of PTSD. However, significant gaps exist from the lack of occupation-specific research. Unlike the military and law enforcement professions, very few funded research efforts have focused on the particular idiosyncrasies associated with the fire service. While fire departments across the country are beginning to understand and appreciate the

importance of employee mental health awareness, many are limited to providing the well-worn EAP and CISD modalities that remain criticized by researchers and the NFFF alike.

These findings have influenced the research by revealing the depth and breadth of the problem and by highlighting the need for continued research into effective culture correcting strategies. As a fire chief that has lost several members to suicide, the problem addressed by this research will serve to add to the current body of knowledge regarding firefighter suicidality and will undoubtedly help to heal a department and community still reeling from the loss of a dedicated, well-liked, and respected firefighter to the weight of the profession and the effects of PTSD.

Procedures

The purpose of this research was to identify an effective strategy that would allow the DFD to improve firefighter mental health awareness. Using the descriptive research method, the author sought to answer the following research questions: a) What have other fire departments done to address firefighter mental health awareness in their department? b) What mental health stressors have emergency service providers identified as contributing factors to post-traumatic stress? c) What barriers are present that are preventing the Dayton Fire Department from having a more substantial impact on firefighter mental awareness?

The research procedures began with the identification of a significant problem affecting the Dayton Fire Department. Once identified, qualitative research questions were developed to encourage respondent authenticity. Next, two surveys hosted by the web-based service provider, Survey Monkey, were created to obtain data based on current DFD employee experiences and observations as well as those from fire service professionals across the United States. A personal interview was conducted with a subject matter expert (SME) in behavioral and mental health

crisis intervention and awareness in addition to an interview of a firefighter who has struggled with the co-occurring illnesses of post-traumatic stress disorder and addiction. Interviews were also conducted with three department members who also had military experience and knowledge about how the United States military provided mental health awareness for soldiers over the last four decades.

The purpose of the Dayton Fire Department Behavioral/Mental Health Awareness Survey (Appendix A) was to gather personal perspective-based data from current members of the Dayton Fire Department. These members were chosen due to their historical knowledge of the department, their industry-specific insight, and their recent experiences regarding the loss of several department members to suicide. The 11-question survey consisted of a combination of Likert scale and multiple-choice survey questions. The survey process used an anonymous, online format due to its uniformity and ease of analysis. To maximize effectiveness, the survey was sent to the Montgomery County Metropolitan Medical Response System's (MMRS) Coordinator, David Gerstner, to be vetted due to his extensive background with community-wide collaborations, research, and analysis.

The survey was designed to focus on identifying the personal attitudes and perceptions of Dayton Fire Department employees as they relate to the effects of job-related stress and how such stress may manifest into symptoms commonly attributed to PTSD. Specifically, the survey sought to determine employee awareness of PTSD signs and symptoms and gauged responses to establish whether PTSD was recognizable in the department among those who self-identified as a sufferer or those who had witnessed PTSD symptoms in co-workers. The survey further looked to measure employee awareness regarding the mental health treatment options provided by the City of Dayton and the Dayton Fire Department.

The survey link was sent through departmental email to 315 members and was available from November 11, 2019, to December 11, 2019. Due to an initially slow response from survey recipients, a reminder email with the link attachment was again sent to the 315 members on December 1, 2019. The recipient group of 315 members included all uniformed department employees, excluding the author and 18 non-uniformed personnel. One-hundred and thirty five of 315 (42.8%) of members responded to the request. The group of recipients was chosen because, as employees and first responders, they were both acutely and chronically exposed to the work-related stresses often associated with PTSD and were uniquely qualified to respond to questions related to conditions within the Dayton Fire Department.

A second survey, also hosted by Survey Monkey, focused on obtaining data from first responders outside of the City of Dayton. Titled, Behavioral/Mental Health Survey (Appendix B) the survey was submitted electronically to the International Association of Fire Chiefs (IAFC) website for distribution and was available from November 11, 2019, to December 11, 2019. Placed in the EFO section, the website provided a recipient population of 1,648 individuals, as verified by the International Association of Fire Chief's (IAFC) Information and Technology (IT) department. The survey response rate for this website was 16.56% and yielded 273 responses. This survey group was chosen because it included career and combination departments across the United States and was limited to Executive Fire Officer Graduates or current students. This survey provided a national perspective on firefighter mental health awareness by including feedback from career and volunteer members beyond the confines of the City of Dayton.

The Behavioral/Mental Health Survey was also placed on the electronic listserv for the Greater Dayton Area Hospital Association (GDAHA). The GDAHA email list included an

additional population of 500 recipients, primarily emergency medical workers and fire service, employees. The survey response rate for this website was 15.20% and yielded 76 responses. The survey recipients were chosen since they represented EMS and fire agencies throughout Ohio, including Auglaize, Butler, Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, Shelby, and Warren counties. The input from these surrounding communities was critically important to better understand the effects of PTSD and suicidality in similar, but unrelated departments.

The purpose of the 13 questions, multiple-choice and short-answer survey was to determine the mental health awareness of members in other fire departments and EMS agencies. An additional purpose of the survey was to provide an understanding of how mental health, PTSD, and causal factors were perceived by those who responded. All respondents were anonymous, and multiple responses from members of the same fire department were detected and included in the study. The survey allowed respondents to omit department name and location to provide a further sense of confidentiality.

On November 26, 2019, a personal interview was conducted with Licensed Professional Clinical Counselor (LPCC) Julie Manuel at a local restaurant (Appendix C). The meeting was audiotaped and then transcribed as included in the appendix. Certified as a Clinical Mental Health Counselor and Employee Assistance Professional, Ms. Manuel specializes in treating PTSD, trauma and mood disorders, sexuality and gender issues, depression, and anxiety. Julie was selected as a subject matter expert (SME) due to her extensive education and vast experience in working with first responders. As a spouse of an emergency service provider, Julie has dedicated much of her career to providing professional counseling and therapy services to first

responders and their families and is acutely aware of the particular stresses found in the emergency services profession.

During the hour-long meeting, Julie was asked questions about her experiences serving as a psychotherapist for many of the Dayton Fire Department members after a recent mass shooting event. While protecting patient confidentiality, Julie was able to provide a personal account of the department's readiness and willingness to provide behavioral and mental health care and identify what the City of Dayton and the DFD might do to provide greater emotional and psychological support to its members. As a mental health provider for other occupations, Julie was asked about what other professions were doing to improve the mental health awareness of their employees. Open-ended questions were used to stimulate respondent authenticity and to provide an opportunity for Julie to expound upon her experiences while providing counseling to DFD members after a critical event. The hour-long interview sought her perspective as a mental health professional and as a family member of a safety forces provider.

A second interview (Appendix D) was conducted with Dayton Fire Department Firefighter/Paramedic James Moe. A military veteran with 12 years of employment with the department, James was selected as an interview subject for his military and fire service and his struggle to combat diagnosed PTSD and substance use disorder (SUD). The audio-recorded interview was conducted at a DFD fire station during James' normal duty day on November 15, 2019. Firefighter Moe expressed no sense of vulnerability and spoke candidly about his constant pursuit to numb the pain and memories associated with his profession. While his inclusion as part of the research is inherently sensitive, the interviewee had reached out to the author previously with a willingness and desire to share his story so that others may benefit from what

he has experienced. His inclusion in the research provided valuable and unfiltered insight into the struggles facing first responders suffering from comorbid PTSD/SUD.

The author also attended numerous seminars and pieces of training to obtain a deeper understanding of the behavioral and mental health challenges faced by DFD employees as well as employees of other organizations outside of the firefighting and EMS professions. These included a Healthy Heroes presentation designed to help first responders mitigate the physical, mental, and emotional stress of the job through the use of science-based exercise, nutrition, and relaxation strategies. Impressed with the focus on improving the overall health of our employees, the DFD partnered with Premier Health to offer the voluntary, no-cost program to all department members as detailed in the included DFD Bulletin #71 (Appendix E).

To better understand how members with no medical training may provide initial help to those experiencing problems such as depression, anxiety disorders, psychosis, and substance abuse disorders, the author completed an 8-hour course on November 14, 2019, and became certified in Adult Mental Health First Aid. Conducted by the Montgomery County Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) and sponsored by the National Council for Behavioral Health, the Warriors Supporting Wellness (WSW) Mental Health Awareness Training teaches basic knowledge and skills to people who may encounter others who are experiencing distress or facing a mental health challenge and also addresses the behavioral health needs for those in the safety forces arena. The non-medical intervention techniques taught in this training help those suffering to restore emotional balance by utilizing self-care strategies and support.

Several limitations were identified during the research. Both Behavioral/Mental Health Surveys (Appendix A and B) attempted to identify a first responder's personal opinion over the

very broad subject matter of mental health. What causes PTSD, what those symptoms look like, and what can be done to minimize or eliminate the causal factors are misunderstood even among scientists who have dedicated much of their careers to this field of study. The surveys may provide subjective data about how first responders "feel" about mental health needs and challenges, but caution should be exercised with inferences made beyond the limited scope. The inherent subjectivity may be found in all aspects of the study. Whether as part of the literature review, surveys, or interviews, the sharing of beliefs and opinions ensures that the respondent's views are captured without the ability to filter any purposeful or unintentional bias (Lykins, 2018, p. 32).

Despite the assuredness of the anonymous survey type, respondents may not have been entirely truthful with their responses for many reasons, resulting in flawed data. Due in part to the sensitive nature of the survey (feelings of stress, self-identification of PTSD, etc.,) respondents may have been hesitant to share their true feelings and opinions. Further, the difficulty in determining if the respondents outside of the DFD were responding as part of the EFO group or as one of the 500 EMS providers included in the listserv link limited the ability to separate fire department mental health awareness concerns from EMS provider concerns.

Lastly, a limitation can also be found in the number of potential respondents that did not participate in the surveys and the number of surveyed members that skipped one or more questions. The author expected to have a response rate much higher than the 42.8% of the 315 members that responded to the DFD Mental Health Awareness Survey (Appendix A) and much more participation in the larger surveyed group.

Results

The purpose of the Dayton Fire Department Behavioral/Mental Health Awareness Survey (Appendix A) was to gather personal perspective-based data from current members of the Dayton Fire Department. These members were chosen due to their historical knowledge of the department, their acute awareness of the department's run volume and mental health awareness activities, and their recent experiences regarding the loss of several department members to suicide. The 11-question survey consisted of a combination of Likert scale and multiple-choice survey questions. The survey process utilized an anonymous, online format and yielded 135 responses from 315 available recipients. Nearly 43% of the department's uniformed force responded and shared their views on the wide-ranging survey as detailed below.

A combination of surveys and subject matter expert (SME) interviews were used to answer the following research questions: a) What have other fire departments done to address firefighter mental health awareness in their department? b) What mental health stressors have emergency service providers identified as contributing factors to post-traumatic stress? c) What barriers are present that are preventing the Dayton Fire Department from having a more substantial impact on firefighter mental awareness? The results and findings of the completed surveys and interviews were critical in providing the necessary information to answer each question below.

The first research question asked: What have other fire departments done to address firefighter mental health awareness in their department? The research shows that most fire departments rely heavily on the use of critical incident stress debriefings (CISD) to prevent or limit the development of post-traumatic stress in first responders who have been exposed to a

critical incident. Nearly 90% (87.97%) of the national respondents and 71.64% of the DFD respondents said that they had participated in a CISD after such an event.

The data further show the perceived value of critical incident stress debriefings to be highly subjective. Nationally, 79.94% of the respondents felt that CISD was extremely helpful (13.69%), helpful (27.71%), and somewhat helpful (38.54%). Sixty-three of the 314 respondents (20.06%) felt that such debriefings were not helpful at all. The perceived effectiveness of CISD to DFD members was less enthusiastic, with nearly 42% of the participating department members stating that they found the after-action debriefings to be unhelpful. The disharmony between surveys was not surprising as there is an over-abundance of wide-ranging opinions regarding the value of CISD. Spoon's (2018) research regarding the efficacy of CISD in a Chicago area department and the NFFF's recent admission to its confusion about how to best provide psychological support to first responders suggests that CISD may not be the panacea for the mental and behavioral ills affecting the American fire service (Spoons, 2018).

An interview (Appendix C) with Licensed Professional Clinical Counselor (LPCC), Julie Manuel, provided the additional insight needed to adequately answer the question about what other fire departments were doing to address their mental health awareness needs. Julie identified multiple progressive techniques and programs currently used by several departments across the country (personal communication, November 26, 2019) (Appendix C). These stress-reducing efforts included intensive outpatient programs (IOP), sensory mindfulness, relaxation therapy, and even the use of emotional support animals. Unfortunately, many of the departments utilizing these cutting-edge stress reduction strategies had also experienced significant or catastrophic events within their jurisdictions. The implication suggests that while some fire

departments are proactively addressing their employee's PTSD needs, many more departments wait until a significant event has already taken place before engaging in such activities.

The research supports that many fire departments focus first on improving employee awareness through education with a greater emphasis on self-care to help manage the negative effects of stress. Clinical Mental Health Counselor and Employee Assistance Professional, Julie Manuel, stated that many organizations are placing more priority on educating their employees about work-life balance, creating better-coping skills, and greater self-awareness in addition to the increased use of available mental health resources (Appendix C). This focus on first responder wellness is commonly exercised through work/life balance, and stress reduction training in addition to wellness fitness initiatives (WFI) programs prevalent throughout the country.

The research also shows that fire departments have been quite successful in educating their members about the respective mental/behavioral health services that are available for its members. Question number one on the DFD Behavioral/Mental Health Awareness Survey sought to determine the department member's overall mental and behavioral health awareness. The results show that the vast majority (91.1%) of the department is aware of the mental health treatment options currently available for their use. None of the 135 respondents skipped the question with fewer than 9% of the members stating that they were unaware of or did not know about the department's current mental health available services. Similar numbers were found from those who responded to the national Behavioral/Mental Health Awareness survey. Question two on that survey also showed that the majority (85.96%) of the respondents knew about the treatment options provided by their respective departments.

What is perhaps less clear for many fire service leaders is how to effectively measure if they are providing too many or too few mental health strategies and treatment options for their members. Nationally, approximately half of the respondents (47.85%) felt that their department was doing "just right" in addressing their department's mental health needs. This figure mirrored that found in Dayton, with 46.62% of its members agreeing with that assessment. Differing opinions were found between the national respondents and those from the DFD in response to department's who were doing too little, or far too little to address their member's concerns. More than half of the national respondents (51%) felt that their department could do better while only 35.34% of the DFD respondents felt that the department should be doing more to address its member's health. However, there has been an abundance of available mental health treatment options to DFD members since Dayton has recently experienced a tremendous year of tragic loss. This influx of resources and heightened awareness certainly contributes to the differences in opinion found among the surveys.

Kettering Health Network's Julie Manuel feels that the continued and effective use of peer support teams is critical for members to begin to speak more openly and freely about mental health issues and job-related stress but also stresses that they cannot do it alone. "The peer support team is critical, but they do need a liaison that is able to provide a more clinical insight into behavioral health and behavioral health services because, unfortunately, we are very reactionary and will wait until something else happens. Then we will call someone in and educate our members when we should have been doing it all along (J. Manuel, personal communication, November 26, 2019) (Appendix C).

The second research question asked: What mental health stressors have emergency service providers identified as contributing factors to post-traumatic stress? This question was

answered through the use of surveys, personal interviews, and through the completion of the Warriors Supporting Wellness (WSW) Mental Health Awareness Training for adult mental health first aid. While nearly every job has some level of stress, this research focused on first responders since they routinely encounter various critical incidents and work in a profession that has consistently been identified as having high suicide rates.

It is important to distinguish between the average stresses that most employees experience within their respective work environment to the stressors that first responders feel may be contributing to PTSD. To distinguish between typical work stress that affects all employees from stressors that may ultimately lead to PTSD, both surveys included a preceding qualifier question so that only those who answered affirmatively were prompted to then identify the nature of their specific stressor. Question number six on the national Behavioral/Mental Health Awareness Survey asked respondents if they currently or ever felt that they had PTSD as a result of their occupation. All 349 respondents answered with more than three quarters (75.36%) stating that they had some PTSD (33.24%) or a little PTSD (42.12%) because of their profession. Not nearly as many members in Dayton felt that they had experienced PTSD because of their profession. Of the 135 respondents, 29 (21.48%) felt they definitely had PTSD, 21 (15.56%) stated that they had some PTSD, and 37 (27.41%) opined that they had a little job-related PTSD. More DFD responders (35.56%) denied feeling like they had any PTSD symptoms compared to 24.64% of the national respondents.

As previously described, the follow-up question on both surveys asked those who did identify some level of PTSD to then identify the offending stressor(s). Respondents of both surveys were provided the following five selections:

- Lack of or disruption of sleep

- Dealing with death and dying
- Run volume
- Family issues (finances, spouse, etc.)
- Other

Respondents that chose "Other" were further prompted to specifically include the stressors that they felt contributed to their perceived PTSD condition. While only those who previously stated that they felt they had some level of job-related PTSD were asked to identify specific stressors, the survey apparatus failed to prevent all respondents from answering the follow-up question. As such, 12 respondents of the DFD survey and 23 respondents of the national survey identified a contributing cause of stress despite having self-identified as suffering from PTSD.

Respondents of both surveys agreed that the lack of or disruption of sleep weighed heavily on their job-related stress. In the DFD survey, the lack of sleep appeared to be tied to a high run volume as 73.73% of the respondents identified the lack of sleep, and nearly identical 71.72% reported run volume as stressors. This same cause and effect was not found in the national survey. While national respondents also chose the lack of or disruption of sleep as the primary stressor (61.54%), only 78 of the 286 responders (27.27%) who answered that question, also selected run volume as a potential PTSD stressor. An interview with a department member clinically diagnosed with PTSD echoed the same sentiment when asked what role high run volume and truncated sleep has on post-traumatic stress. "An absurd amount. You are on the medic, you are up all night, and you come home and sleep. You wake up and it's the worst feeling in the world, so you drink to feel better. Then you argue, that's what I found. People are getting burned out" (J. I. Moe, personal communication, November 15, 2019) (Appendix D).

The national survey respondents identified dealing with death and dying (56.29%) as the second most recognized PTSD stressor compared with 40% of DFD respondents who agreed with that sentiment but chose it as the third most common stressor. The stresses of family issues ranked higher (38.81%) among national respondents than in Dayton, with 32.32% of its respondents selecting that specific stressor. Both surveys resulted in nearly identical percentages, with 27% of each group choosing the "Other" option and typing in a response other than those provided.

Respondents of both surveys who chose the "Other" stressor option ranged from identifying very broad stressors such as "politics" to citing very specific traumatic events or critical patients. Fire department and city administration leadership were also commonly included as offending stressors, as was the cumulative effect of multiple tragedies throughout a career. All of the responses are included in the appendix (Appendix A and B) and support the notion that while first responders often experience similar job-related stressors, the effects of such stressors vary from person to person.

Clinical Mental Health Counselor and Employee Assistance Professional, Julie Manuel stated that "PTSD is unique in that not everyone gets it. It is not a cold where if someone sneezes, everyone gets it. Some of us are more resilient than others; some of us have better-coping skills, even before we witness these tragic things (J. Manuel, personal communication, November 26, 2019) (Appendix C). Ms. Manuel states that she often leaves PTSD out of many conversations, referring to trauma-related events instead because the stigma of PTSD can be overwhelming for some. "I leave PTSD out and say trauma-related events because everyone reacts differently. It's kind of like well if you have it, then I should have it, well that's not necessarily true, and it's not a bad thing if you do or you don't. It is what it is, and knowledge is

power. So, if we can educate people on, you may not have 10 of the symptoms, but maybe you have one. Does that mean you have PTSD, no, it just means that maybe you need to talk about things that are going on or work to develop your coping skills" (J. Manuel, personal communication, November 26, 2019) (Appendix C).

Ms. Manuel's statement above underscores a very serious problem within the fire service. Namely, what exactly is PTSD, and does one need to be clinically diagnosed to have it? The data suggest that many first responders feel that their co-workers are suffering from PTSD, even if those co-workers do not self-identify as having PTSD. Eighty-three percent of the DFD survey respondents said that they often (25.19%) or occasionally (58.52%) worked with co-workers whom they suspected were dealing with or displaying signs of PTSD. An alarming 92.26% of the national survey respondents felt that they too had often (26.07%) or occasionally (66.19%) worked with co-workers whom they suspected were dealing with or displaying signs of the disease.

As a Licensed Professional Clinical Counselor (LPCC), Ms. Manuel conducted numerous individual and group support sessions for DFD members following the department's mass shooting and employee suicide incidents. When asked her opinion on the number of Dayton Fire Department employees who were suffering from PTSD, Julie stated: "I would say well over half of the department" (J. Manuel, personal communication, November 26, 2019). Her opinion was supported by firefighter James Moe, who was clinically diagnosed with PTSD after a military tour in Kosovo and years of service with the DFD. "No one talks about it. I am not going to come up to you and say, I've been feeling really bad lately and I'd like to talk about it, we just don't do that" (J. I. Moe, personal communication, November 15, 2019) (Appendix D).

Fortunately, first responders appear to be willing to help others who may be suffering from work-related depression, PTSD, or some other behavioral health issue. Respondents of the national behavioral health survey indicated that the vast majority (93.70%) would attempt to help a struggling co-worker, while 89.63% of the DFD respondents said that they, too, would try to help. When asked how they might try to help, 79.4% of the DFD respondents and 80.36 of the national respondents stated that they would talk to the co-worker.

The third research question asked: What barriers are present that are preventing the Dayton Fire Department from having a more substantial impact on firefighter mental awareness? Respondents of both surveys were asked to identify any barriers that existed that they felt prevented those struggling with behavioral health needs from asking for help. Nearly 82% of the DFD respondents stated that the perception of weakness from others as the most significant barrier. Similarly, respondents from the national survey overwhelmingly agreed with nearly 87% of those surveyed identifying the perception of weakness from others as a critical barrier.

Despite years of substance abuse and failed relationships due in part to PTSD, firefighter Moe was also hesitant to ask for help because of the stigma of weakness associated with it.

> "Everyone knows that you don't want to be a pussy." You don't want to be that guy; you want to feel like a man, you don't want to be weak. You don't want to go cry. Everyone says, you know what you signed up for, and everyone thinks we have this damn S on our chest like we are invincible. Nothing matters because we push so much inside" (J. I. Moe, personal communication, November 15, 2019) (Appendix D).

Professional counselor, Julie Manuel suggests that fear of others finding out, or the stigma associated with people seeking behavioral health services is one of the biggest barriers that is preventing others from getting the mental help they need.

> "The stigma of receiving mental health services has really impacted our society at large. Historically speaking, if you had a mental health issue, you were sometimes literally locked in chains and treated extremely poorly because we just didn't know. Of course, knowledge is power, and we have evolved over time, but the stigma of if I have depression, or if I have anxiety, if I have a personality or bipolar disorder, I think that people are fearful of "what will others think of me if they know?" So stigma is definitely a barrier (J. Manuel, personal communication, November 26, 2019) (Appendix C).

Many departments have begun to send their members to mental health awareness trainings. One of those service providers is the National Council for Behavioral Health, which teaches mental health first aid throughout the United States. The author completed an 8-hour course and became certified in adult mental health first aid. During the course, the instructor highlighted the reality that many people would rather suffer in silence rather than risk ridicule by seeking help. The class manual, *Mental Health First Aid USA* (2015), further identifies stigma as "one of the biggest barriers to individuals seeking treatment and therefore is one of the biggest barriers to recovery.

Julie Manuel feels that first responders are less willing to speak about their mental health concerns because of the role that first responders play. "The fire service is different because I think that the fire service is here to serve others and so the perception is that "we are the ones that are going to run into the burning buildings" I've heard it repeatedly, "we are the heroes," "we are not supposed to be weak, to cry, or show emotion." when in reality, that is exactly what is healthy, and what we have to do" (J. Manuel, personal communication, November 26, 2019) (Appendix C).

While the perception of weakness from others was identified as the most commonly shared barrier to behavioral health treatment, several other barriers were also identified in the surveys and interviews. The lack of knowledge about treatment options was the second most commonly identified barrier with 34.59% of the DFD respondents and 52.06% of the national respondents indicating that they shared some confusion with how to get help best. Ms. Manuel bolstered that position, suggesting that fire service's culture of compartmentalizing trauma to protect the individual may be doing more harm than good. "When it relates to trauma, I think that people are just used to compartmentalizing, so much so that they don't know. So maybe an education barrier? Witnessing trauma daily on the job, but I think from an education standpoint, it is vital and critical that we de-compartmentalize that type of behavior. Pushing all of the traumas that first responders see each day into little compartments is probably a very big barrier that people have run into (J. Manuel, personal communication, November 26, 2019) (Appendix C).

Nearly half (47.65%) of the national survey respondents and 30.83% of the DFD respondents felt that the lack of training about the signs and symptoms of stress was a present barrier that was preventing their respective fire and EMS departments from having a more substantial impact on mental health awareness. Julie Manuel suggests that historical fire department culture may make recognizing the symptoms of stress more difficult as members tend to compare themselves with those who are also subject to the same traumatic experiences.

> "I've had conversations with many of your members who said, well others before me saw a lot of bad things, and they never got help, and my response is often, yes, but do you know how many divorces they have been through, or how many OVIs they might have had? How many alcohol and drug treatments have they been through? We have to look at

what were the self-destructive behaviors they were utilizing to cope with the trauma they were dealing with (J. Manuel, personal communication, November 26, 2019).

The respondents of both surveys were given the option to select "Other" when asked to identify any barriers that existed that they felt prevented those struggling with behavioral health needs from asking for help. One of the issues identified by respondents of both surveys was the current lack of recognition from the Bureau of Workers Compensation (BWC) to recognize PTSD as a workplace injury or illness. Respondents feel that lack of medical coverage for PTSD is preventing first responders from appropriately identifying the early onset of PTSD and slowing access to professionals that are capable of helping them to work through the mental health concerns.

Lastly, the final question on the national survey asked respondents about their views regarding the significance of first responder suicide in the service. Only two of the 349 respondents (0.57%) felt that the issue lacked importance. While nearly all respondents agreed that first responder suicide was a critical issue, the research showed that the solution to the problem is extremely complex and will require a commitment from mental health professionals, first responders, and current and future fire service leaders to address the underlying culture that threatens to exacerbate the issue.

Discussion

The extensive literature review coupled with multiple research components including a personal interview with a mental health expert, an interview with a first responder diagnosed with PTSD and substance abuse issues and two focused surveys of first responders led to many discoveries about the behavioral health needs of first responders. The results of this research contribute to the body of knowledge and answer the following research questions: a) What have

other fire departments done to address firefighter mental health awareness in their department? b) What mental health stressors have emergency service providers identified as contributing factors to post-traumatic stress? c) What barriers are present that are preventing the Dayton Fire Department from having a more substantial impact on firefighter mental awareness? However, it is critically important to explore further the relationship between the results of this study and the specific findings of others to fully synthesize the information.

The American fire service has been slow to warm to Viktor Frankl's contention that "an abnormal reaction to an abnormal situation is normal behavior" (Frankl, 1959, p. 33). Instead, many members continue to suffer in silence from behavioral health issues because of the fear they feel should others find out that they have asked for help. While survey respondents and multiple studies agree that PTSD is a significant issue among first responders, changing the fire service culture from "suck it up" to "it's okay to ask for help" will take some time.

The IAFF Center of Excellence for Behavioral Health Treatment and Recovery acknowledges the prevalence of first responder hesitation when asking for help due to the stigma associated with mental health. The center has identified the reduction of the mental health stigma as a high priority and suggests that the fire service can begin to reduce the stigma by adhering to the following habits:

- ✓ Above all, take care of your own mental and emotional health
- ✓ Learn facts and statistics about common behavioral health issues that impact the fire service
- ✓ Show empathy not only to the public but to each other
- ✓ Avoid stereotyping people or crew members who have a behavioral health disorder
- ✓ Explore peer support resources in your local or department

- ✓ Become involved in the community
- ✓ Avoid unhelpful comparisons among fellow firefighters
- ✓ Embrace and empower others who choose to seek treatment
- ✓ Encourage people who are struggling to seek treatment
- ✓ Inform and educate the community about behavioral health ("Mental Health Stigma," 2019)

Several respondents from both surveys reported the fear of discipline or loss of employment as a barrier that was preventing them from seeking mental health help. This perception may be perpetuated by the typical process that employees often face when attempting to manage their behavioral health needs. Jackson (2017) identifies divorce, alcohol abuse, and discipline issues at work as secondary effects of PTSD. These secondary effects, especially workplace discipline, often become the catalyst that forces the employee to ultimately seek treatment. Unfortunately for many employees that are suffering in silence, the first step that they take towards addressing their mental health needs comes with employee assistance programs (EAP) that are often mandated as part of the workplace disciplinary process.

This position is supported by a case study of the effects of post-traumatic stress disorder on operational fire service personnel in the United Kingdom (Kahn et al., 2017), which found that depression, anxiety, and substance abuse that commonly result from PTSD have a profound effect on employees and the organizations they serve. These frequently undiagnosed or misdiagnosed responses to PTSD manifest in extended periods of absence, increased health and safety risks, and resignations and dismissals (Khan et al., 2017). This relationship between employee fear of discipline when asking for help for their mental health needs and any actual discipline rendered as a byproduct of PTSD influenced behavior may provide an opportunity for

employers to identify troubled employees earlier in the self-destructive process and warrants further study.

The need to develop better employee resiliency and coping skills to combat PTSD is heavily documented and was championed by Clinical Mental Health Counselor and Employee Assistance Professional, Julie Manuel, during a personal interview. Julie includes that far too often, employees attempt to self-medicate in an attempt to cope with the trauma they have witnessed (J. Manuel, personal communication, November 26, 2019) (Appendix C). She highlights the prominence of co-occurring or dual diagnosis of mental health issues and substance abuse among healthcare workers, fire service personnel, and law enforcement (J. Manuel, personal communication, November 26, 2019) (Appendix C).

DFD firefighter James Moe shared his struggle with alcohol and drugs as he tried to self-medicate to mask his feelings and to forget about his work-related experiences. James was able to identify the specific incidents that attributed to his PTSD and substance abuse after a thirty-four-day in-patient treatment at the IAFF Recovery Center in Maryland. "No one outside of the fire service understands or knows what we see. Nobody should have to ever see what we see as far as a two-month-old being thrown against a wall because she was crying" (J. I. Moe, personal communication, November 15, 2019) (Appendix D). His feeling of isolation and reliance upon self-medication is far from atypical and is well-researched.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 20% of all first responders with PTSD also have a substance use disorder (SAMHSA, 2018). Acknowledging the difficulties that first responders face while struggling with the co-occurring illnesses of PTSD and substance abuse, one can begin to appreciate the difficulties that employees face in attempting to strengthen their resiliency while creating healthy

coping skills. Surveys and interviews of this research highlight the dichotomy between the repeated exposure to traumatic events that can cause PTSD and the disruption of sleep that can make it exceedingly difficult to engage and function in traditionally accepted coping mechanism endeavors such as mindfulness and exercise.

Respondents of both surveys agreed that the lack of or disruption of sleep weighed heavily on their job-related stress. Nearly 74% (73.73%) of those taking the DFD survey and 61.54% of the national survey respondents recognized the damaging effects of sleep deprivation on their mental health. These numbers compare favorably with a 2018 SAMHSA study that found that 72% of EMTs suffer from sleep deprivation (SAMHSA, 2018). Further, two of the hyperarousal symptoms of PTSD is falling asleep and staying asleep, and studies have found that sleep problems are one of the most commonly reported symptoms reported by people with PTSD.

PTSD was a primary focus in this research due to the prominent role the diagnosis plays in suicide and suicide ideation. An unknown affecting all first responder organizations is the actual number of employees that suffer from PTSD symptoms. A high number of respondents of both surveys either reported that they were suffering from PTSD or identified coworkers who they felt were suffering from PTSD. Seventy-five percent of the national respondents self-reported that they had some level of PTSD, while 64.45% of the DFD respondents felt that they were also suffering from the illness. Further, the extremely high number of respondents who identified PTSD symptoms in coworkers (92.26% and 83.71% respectively) suggests that PTSD is rampant among first responders.

While such a declaration may be cause for alarm, some feel that PTSD has now become the “dirty helmet” of the fire service. Coined the “Dirty Helmet Syndrome” by Aurora (Illinois)

Fire Department's Battalion Chief, Jason Demas, the reference suggest that some first responders may self-diagnose as suffering from PTSD to show others that they too have had significant exposure to fires and other traumatic events (J. Demas, personal communication, October 16, 2019). This potentiality suggests that while employers should treat all reports of PTSD seriously, an effort should be made to obtain a professional diagnosis so that competent providers can initiate a proper form of treatment.

The research also examined what other fire departments were doing to address firefighter mental health awareness in their department. Fortunately, department members and respondents of the national survey showed to be well aware of the mental and behavioral health services that were provided by their respective departments, with more than 85% of the national respondents and nearly 92% of the DFD respondents reporting their awareness of treatment options. Contemporary research agrees as a Texas A&M University study (Gulliver et al., 2018) examined the access, attitudes, and preferences of more than 2,000 professional firefighters and found that 81% of the participants reported that they had access to behavioral health services through their departments (Gulliver et al., 2018).

Respondents of both surveys identified CISD as a typical organizational response after crews have experienced a traumatic incident. Despite 20% of the national respondents and 41.67% of DFD respondents stating that they found no value in such debriefings. The growing concern over the efficacy of CISD is shared by the NFFF which recently acknowledged that it was currently uncertain how to adequately provide psychological support to first responders since "research has raised significant concerns about intervention and treatment approaches that have been and are to this day commonly used with fire service personnel" ("Everyone Goes Home," n.d., para. 2).

The question regarding the value of CISD as an immediate intervention to be used following a traumatic experience is nothing new. A 2005 study of CISD efficacy (Barboza, 2005) found that CISD "is not clinically efficacious" and that while many researchers have identified problems with CISD, those studies that support CISD "are not empirically sound" (Barboza, 2005, p. 64). Relatedly, an American Red Cross Advisory Council on First Aid, Aquatics, Safety, and Preparedness (ACFASP) scientific review of critical incident stress debriefings found:

> There is no convincing evidence that psychological debriefing or group debriefing are effective in reducing PTSD. CISD/CISM interventions have not been shown to be effective in either eliminating or lessening the development of PTSD and should not be used for rescuers following a potentially traumatizing event. There is evidence that CISD/CISM interventions may have deleterious effects by interfering with normative post-trauma reduction resiliency (American Red Cross, 2010, p. 6).

Another increasingly popular post-trauma strategy employed by many fire departments to address mental health awareness is the use of peer support teams. While a recent study revealed that 67% of seasoned firefighters would rather talk to their spouse or a behavioral health professional instead of another firefighter or officer about their mental health issues, 31% of the younger firefighters stated that they would seek out other department members for support (Gulliver et al., 2018). To ensure peer support team success, clinical mental health counselor, Julie Manuel, extols the critical need to marry the management team's support to the members of the peer support team.

> " I would explain to the peer support team that your command staff is really leaning into the mental health awareness, behavioral health services, so I think it is more about a

> "buy-in" approach from them. I think that your peer support team is vital and critical for that, but they must have the same belief that your command staff is very on-board with this. Everyone is on the same team; we are all on the bench together, trying to figure out what is the best play for our team" (J. Manuel, personal communication, November 26, 2019).

While there might be reservations experienced by some participants for any treatment option, peer support training has become a standard utilized by many in high-risk occupations to meet the legal and moral duty to care for their employees. Peer support programs have also been credited with beginning to lessen the stigma commonly associated with those seeking mental health assistance (Creamer et al., 2012). A pilot study designed to evaluate the efficacy of peer support programs found that participants who completed such trainings "demonstrated increased knowledge concerning their ability to identify stress injuries, initiate and maintain conversations, motivate peers to follow through with help-seeking behavior, and provide acute stress management" (SAMHSA, 2018, p. 12).

The team approach to treating PTSD is commonly utilized by various treatment centers throughout the country that specialize in treating first responders with PTSD and substance abuse issues. Fire departments and other first responder organizations often send struggling members to these treatment centers for intensive, in-patient care. Current DFD employee and recovering PTSD and substance abuse survivor, James Moe described his treatment at the IAFF Recovery Center in Maryland as a place that saved his life. "It's a behavioral and mental health treatment center that also treats substance abuse." James received around the clock individual and group counseling with a team of professionals and was comforted to find other fire service professionals from all over the country there, struggling with the same issues. "It absolutely

saved my career and my life" (J. I. Moe, personal communication, November 15, 2019) (Appendix D).

The interpretation of this study underscores a critical need to promote mental and behavioral wellness among first responders. The surveys, interviews, and literature show that employee assistance programs (EAP) and critical incident stress debriefings (CISD) are not enough to adequately address the needs of first responders who are regularly confronted with exposure to traumatic events. Fire service leaders must promote and strengthen employee resiliency and ensure that it is supported and encouraged through all levels of their respective organizations.

The organizational implications of this research are immense. The research sought to identify methods for the DFD to better address the mental health needs for its members. Additionally, the study focused on identifying present barriers that were preventing the Dayton Fire Department from having a more substantial impact on firefighter mental awareness. The research revealed that while the City of Dayton and the Dayton Fire Department have been extremely proactive with providing mental health treatment options, the continued fallout and psychological impact from a very tumultuous year that included a mass shooting and suicide of a beloved firefighter has taken a heavy toll.

Careful analysis of the DFD survey also highlights an organization nearing its breaking point regarding employee wellness. The high number of employees who feel that they have witnessed PTSD symptoms among coworkers, and those who identified as suffering from PTSD themselves suggests that rapid intervention is required. While the high run volume and sleep deprivation appear to be causal triggers, much more research is needed to adequately understand

the depth and breadth of stressors that are negatively affecting the mental and behavioral health of DFD members.

Recommendations

The depth of the research problem was revealed through the substantial background and significance and literature review processes. The alarming incident rate of first responder suicide identified in this research implores that a concerted effort is made to identify and reduce the job-related stressors that are contributing to PTSD, and in some cases, suicide. The data obtained from the multiple surveys and personal interviews with subject matter experts were vital to determining the following four recommendations.

The first recommendation is for the City of Dayton to provide a comprehensive Behavioral Health Program (BHP) for fire department members. Managed by a professionally licensed behavioral health service provider, the program would assist employees with recognizing and understanding the signs and symptoms of PTSD and would help strengthen employee resiliency by focusing on behavioral health education and evidence-based stress prevention techniques. The BHP would provide no-cost clinical support and facilitate confidential treatment for members who are suffering from depression, anxiety, and other psychological stresses. The author suggests that the BHP could be managed within the Employee Assistance Program (EAP) umbrella and champions the National Fallen Firefighters Foundation's Fire Service Behavioral Health Management Guide as the principal document for program development (Lykins, 2018, p. 51).

The second recommendation is for the development of a comprehensive training program designed to educate department members on how to prevent, reduce, and recognize the signs and symptoms of PTSD. Since EMTs, firefighters, and officers have daily contact with each other,

they may be the first to notice a fellow employee who is having difficulty coping with stress. This department-wide training should include a standard operating procedure (SOP) that details the confidential use of a non-punitive reporting process for employees suspected of exhibiting stress-related behaviors. Department officers should additionally be trained to look for stress-related cues among crew members such as reduced work performance and increased absenteeism and encourage those employees to seek treatment for their mental health needs.

The third recommendation is for the inclusion of annual mental health checkups as part of a comprehensive WFI program. Since emotional wellness has been determined to be just as important as physical health, the identification of early conditions such as anxiety and depression would allow for earlier treatment and could potentially reduce the instances of PTSD. Focused yearly mental health screenings should be inseparable from annual physicals and viewed as an integral component of preventative care. Each mental health checkup should include a brief one-on-one consultation with a psychiatrist or psychologist with available no-cost treatment plans for those who require follow-up care.

The final recommendation is for increased support and financial investment into improving the current peer support team. Improvement in the peer support team can be made by partnering with mental health providers that are specifically trained in PTSD treatment for first responders. These trained professionals would serve as a liaison between the healthcare system, the employee, and management to ensure that employee wellness was paramount. This consistent relationship with a medical health professional that understands and appreciates the complex issues that first responders face should have a tremendous impact on reducing the stigma currently associated with those seeking help for their mental health needs.

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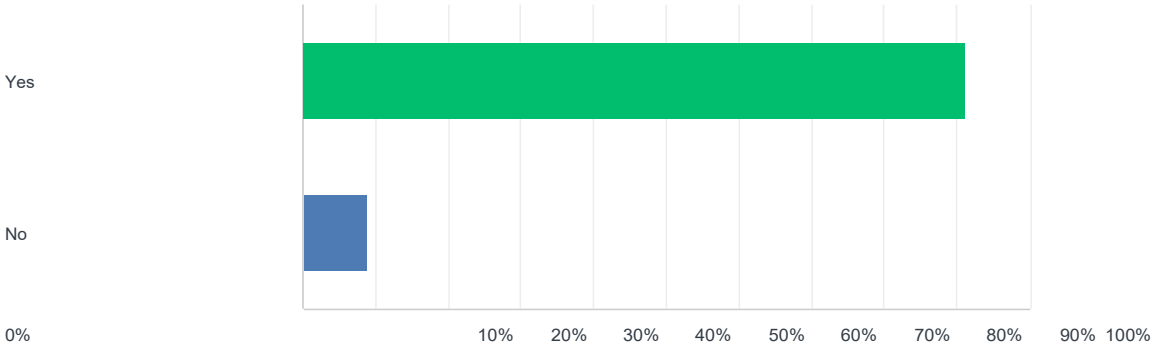
Appendix A

Dayton Fire Department Behavioral/Mental Health Awareness Survey

Q1 Are you presently aware of the mental/behavioral health treatment options available to you as a member of the Dayton Fire Department?

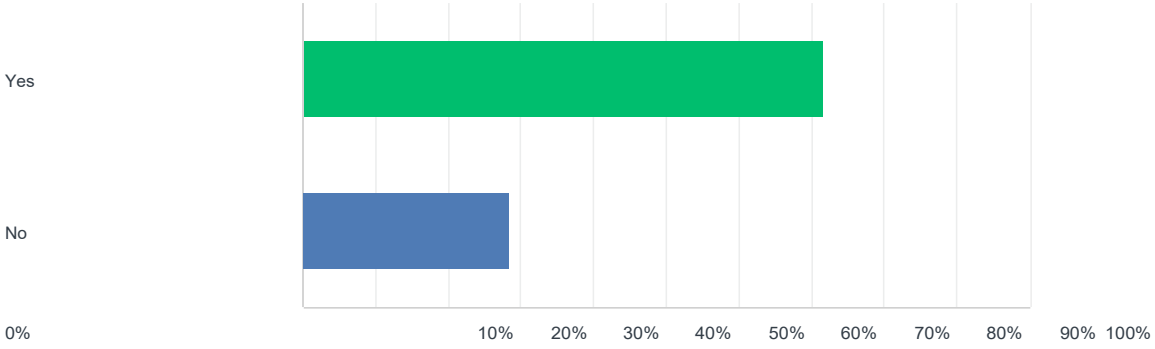
Answered: 135 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	91.11%	123
No	8.89%	12
TOTAL		135

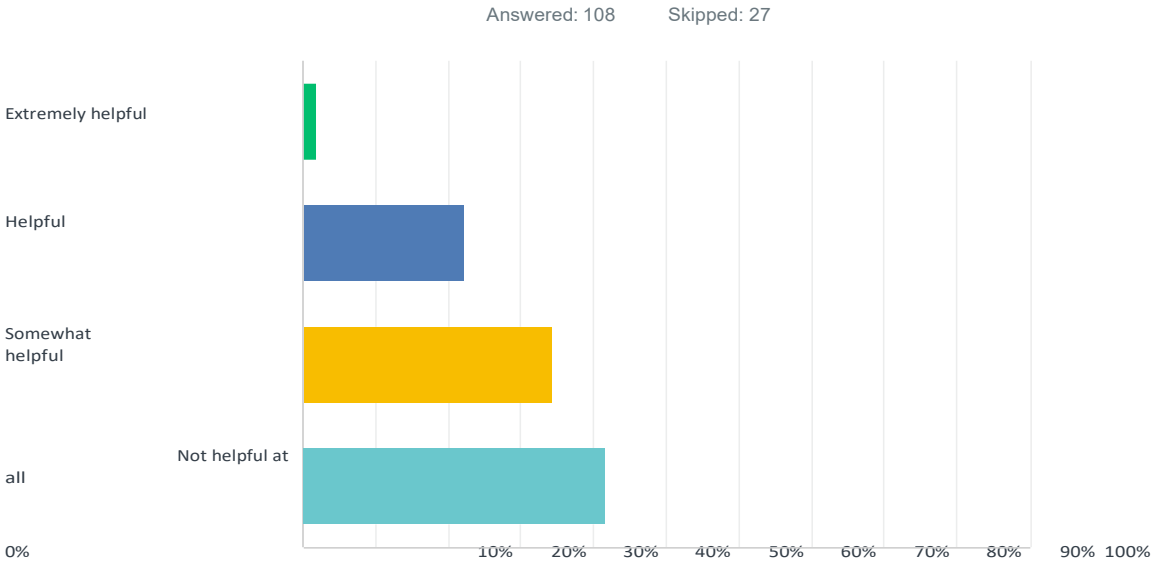
Q2 Have you ever participated in a critical incident stress debriefing (CISD) after a traumatic event?

Answered: 134 Skipped: 1



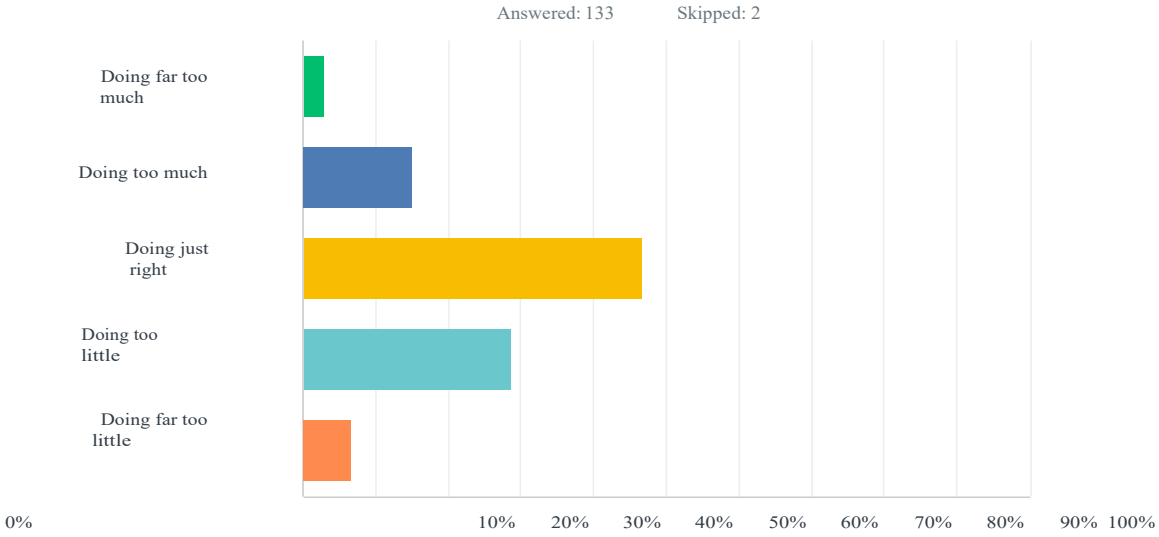
ANSWER CHOICES	RESPONSES	
Yes	71.64%	96
No	28.36%	38
TOTAL		134

Q3 If you answered yes for question #2, Did you find the critical incident stress debriefing helped to eliminate or reduce your stress related to that event?



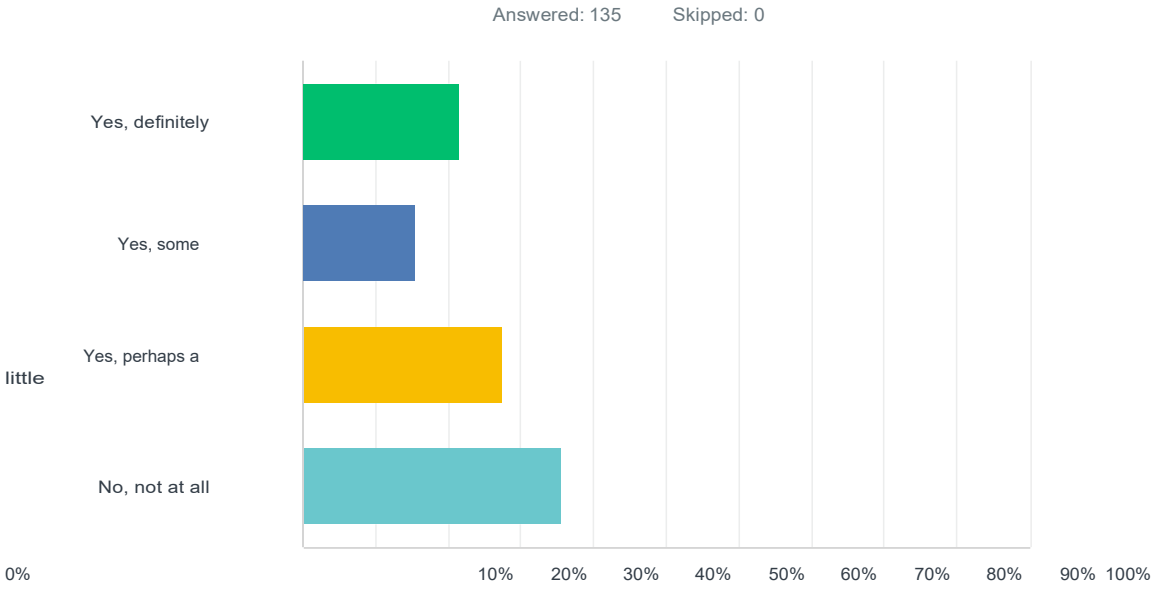
ANSWER CHOICES	RESPONSES	
Extremely helpful	1.85%	2
Helpful	22.22%	24
Somewhat helpful	34.26%	37
Not helpful at all	41.67%	45
TOTAL		108

Q4 Regarding mental health awareness, how would you say the DFD is doing to address the mental/behavioral health needs of its employees?



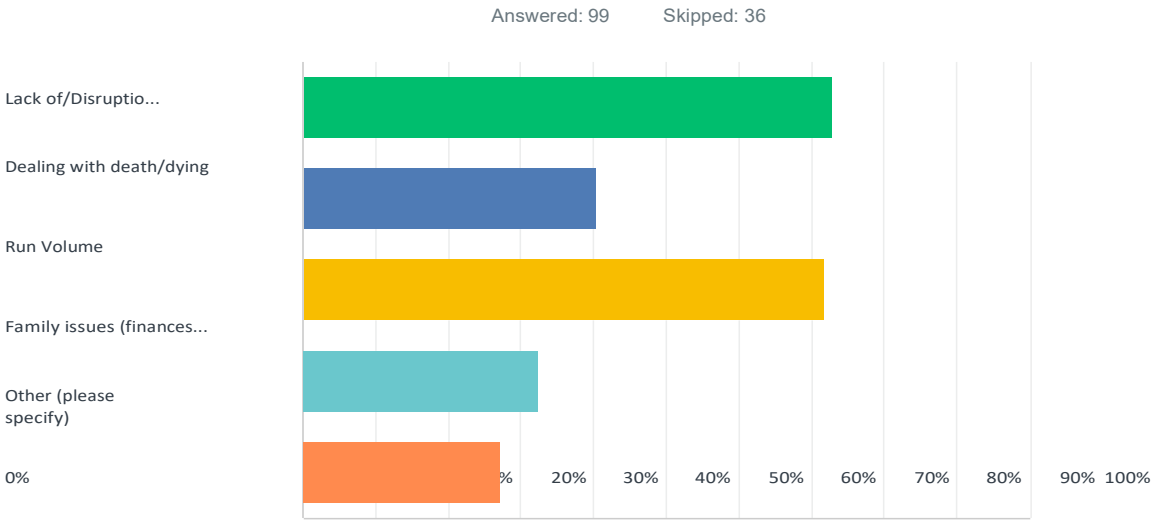
ANSWER CHOICES	RESPONSES	
Doing far too much	3.01%	4
Doing too much	15.04%	20
Doing just right	46.62%	62
Doing too little	28.57%	38
Doing far too little	6.77%	9
TOTAL		133

Q5 Do you feel or have you ever felt that you have PTSD as a result of your occupation?



ANSWER CHOICES	RESPONSES	
Yes, definitely	21.48%	29
Yes, some	15.56%	21
Yes, perhaps a little	27.41%	37
No, not at all	35.56%	48
TOTAL		135

Q6 If you answered yes to question #5, what do you attribute as a leading cause of that stress? Check all that apply



ANSWER CHOICES	RESPONSES	
Lack of/Disruption of sleep	72.73%	72
Dealing with death/dying	40.40%	40
Run Volume	71.72%	71
Family issues (finances, spouse, etc.)	32.32%	32
Other (please specify)	27.27%	27
Total Respondents: 99		

Showing 27 responses

Compassion fatigue

Overwhelming change within the fire department operation. ESO, Kronos, etc

Way to much stuff that keeps getting piled onto us and the constant threat of corrective action if we mess up anything. ESO, Kronos, target solutions, inspections, hydrants, continuing education, and the call volume. We have very little training on any of the new things we are doing, but we get reminded every day that if we make a mistake, we will get put in corrective action.

Both lack of sleep and run volume

Lack of faith in the “brotherhood.”

inadequate staffing

Lack of trust in city staff

All of the above, plus tornados and mass shooting and FD/PD deaths and technology overload fatigue and
depression, anger, outbursts

No enough resources to help ems,

The unwillingness of city management to address the heavy run volume. It will require a huge commitment. To handle the run volume that is increasing significantly every year, I believe that the city needs to place two more engines in service and four more medics. Stop crossing E8 and put E10 back in full time in addition to 2 more Engines. I understand that it would be extremely costly. But this is the reality we have. Often it feels hopeless because we all know the city will not address these issues. They would rather spend money on real estate. They would rather pass taxes to send kids to preschool. Those programs are nice but when the foundation is crumbling it needs to be fixed. The hopelessness makes us feel unappreciated. Sure, they love to tell us how much they appreciate us, but they aren't willing to do the necessary things. We understand that it isn't the chiefs staffs fault. We understand that you all are doing the best you can with what you have. But it feels like city management are a bunch of bullies. That kind of hopelessness, along with the run volume, the severity of the calls, and lack of real support contributes heavily to the average members PTSD.

Trauma witnessed at runs

The DFD approves a policy of forcing medics and EMTs to work 36 hours straight on a medic unit. While openly acknowledging that the run volume is far too high, and medics and EMTs already worked 8 hours of OT the previous night. The DFD does not care about mental health, just the bottom line. They force people to work exhausted, which will kill someone someday.

reliving the incident in my mind

Unable to disconnect from job; calls / texts/ emails when off duty.

Poor diet in the firehouses. Lack of quality physical fitness opportunities on-duty.

A feeling of mistrust from city hall, lack of support from city hall and headquarters, severe mismanagement of many facets of the fire department

NA

N/A

unknown

Departmental response

Lack of concern for employees well being

Assaulted physically and verbally on the job

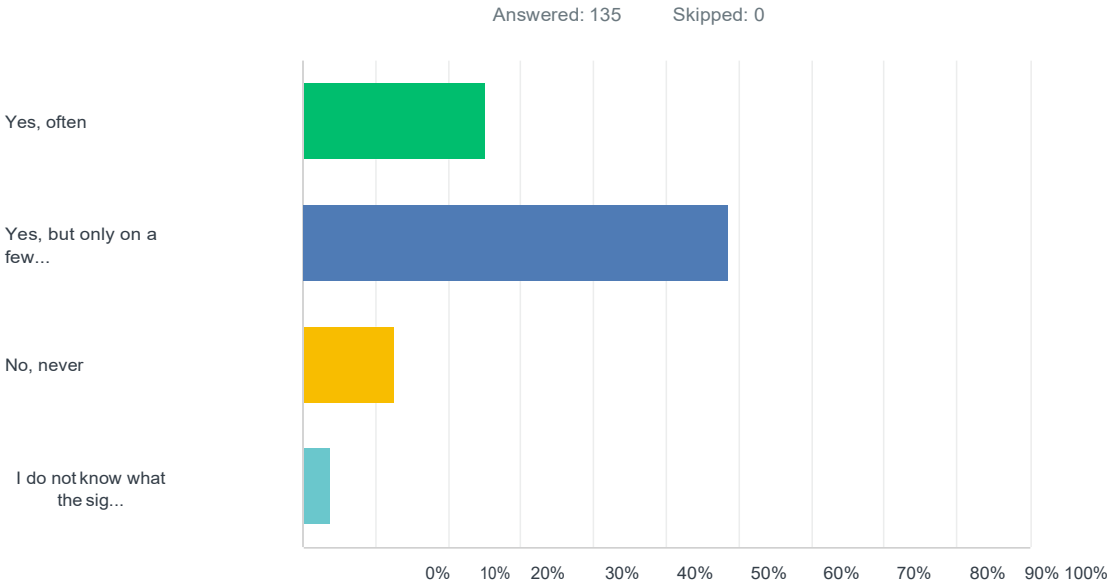
I am feeling like I work for an organization that does not care about its employees. The only concern about our run volume is that we create mutual aid, not that we are beat down every day. Our equipment (Everything from medic units to the monitors) is sub-par for the job we are expected to do as well.

Single PM on medics

Alcohol

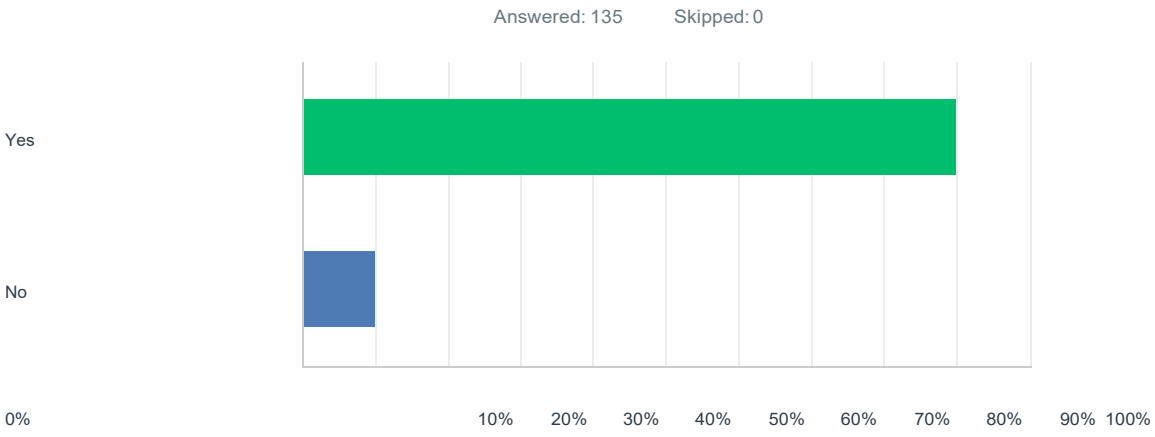
An accumulation of runs overtime in addition to the obviously high stress runs such as the Oregon district or the run on Brian Poole

Q7 Have you worked with co-workers whom you suspected were dealing with or displaying signs of PTSD?



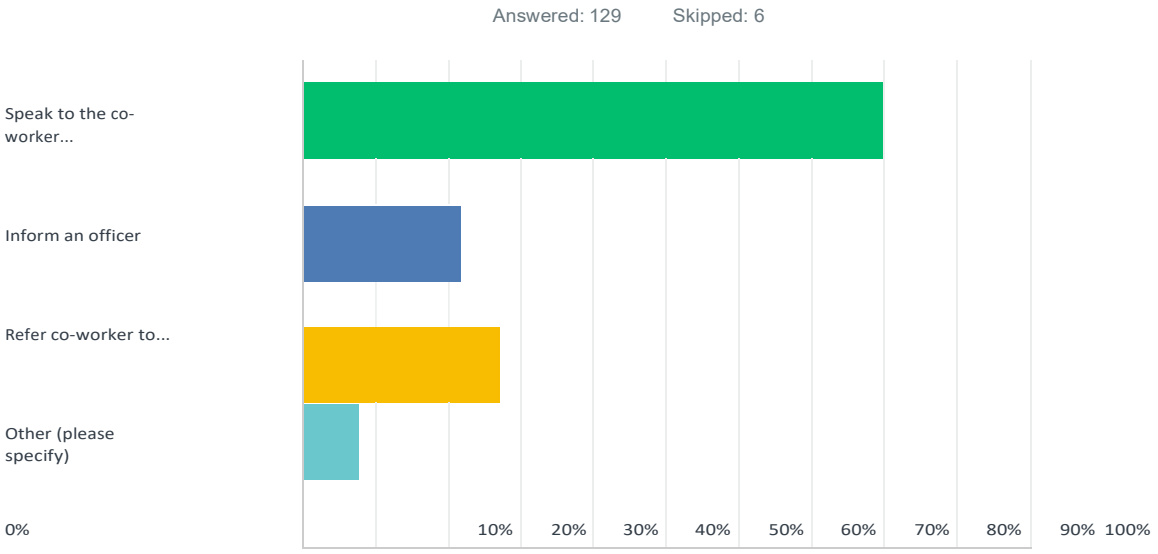
ANSWER CHOICES	RESPONSES	
Yes, often	25.19%	34
Yes, but only on a few occasions	58.52%	79
No, never	12.59%	17
I do not know what the signs of PTSD are	3.70%	5
TOTAL		135

Q8 If you suspected that you or a co-worker were suffering from PTSD, depression, or some other behavioral health issue, would you try to seek help or get help?



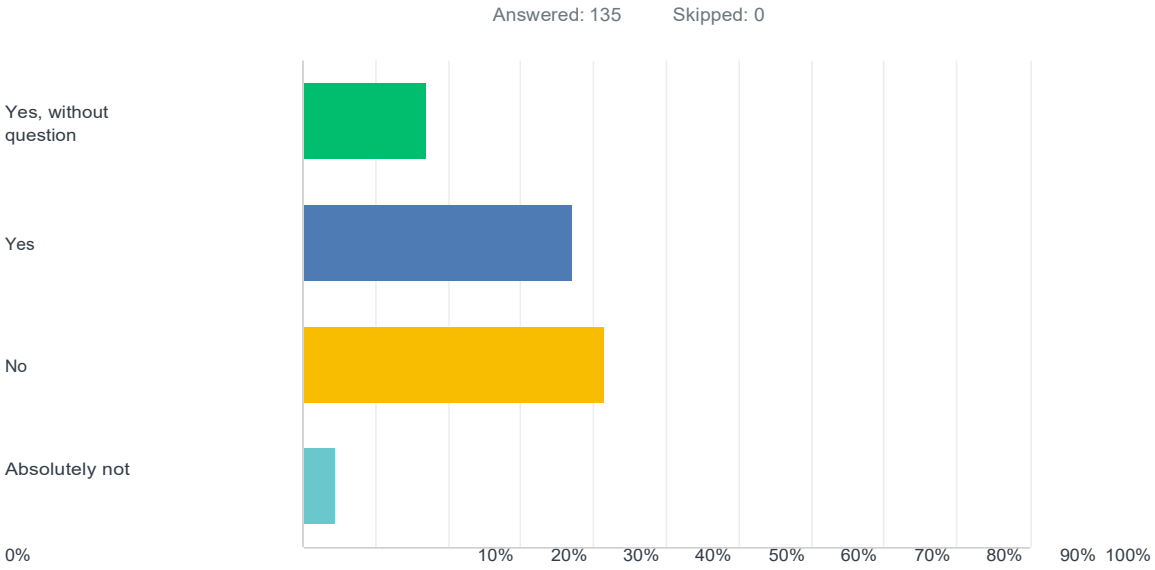
ANSWER CHOICES	RESPONSES	
Yes	89.63%	121
No	10.37%	14
TOTAL		135

Q9 If you answered yes to question #8, how would you most likely try to help another?



ANSWER CHOICES	RESPONSES	
Speak to the co-worker directly	79.84%	103
Inform an officer	21.71%	28
Refer co-worker to EAP confidentially	27.13%	35
Other (please specify)	7.75%	10
Total Respondents: 129		

Q10 Do you feel that there is a culture within the DFD that prevents members from asking for help for their emotional or psychological needs?



ANSWER CHOICES	RESPONSES	
Yes, without question	17.04%	23
Yes	37.04%	50
No	41.48%	56
Absolutely not	4.44%	6
TOTAL		135

Showing ten responses

peer support

checking up on them

Peer Support

Most of the time we deal with this stuff by talking it out. Our coping skills are tied heavily to our bonds of the brotherhood, specifically our comradeship. I have heard from members about the low quality of the EAP. Without giving away my identity, I'm someone these complaints tend to come to. One member reported that the EAP counselor fell asleep while in session. That is sad. I encouraged the member to take it up with HR. Another member told me that he found the service to be totally unhelpful and that they were completely unable to relate and that they seemed disinterested

Call peer support to reach out to that person

N/A

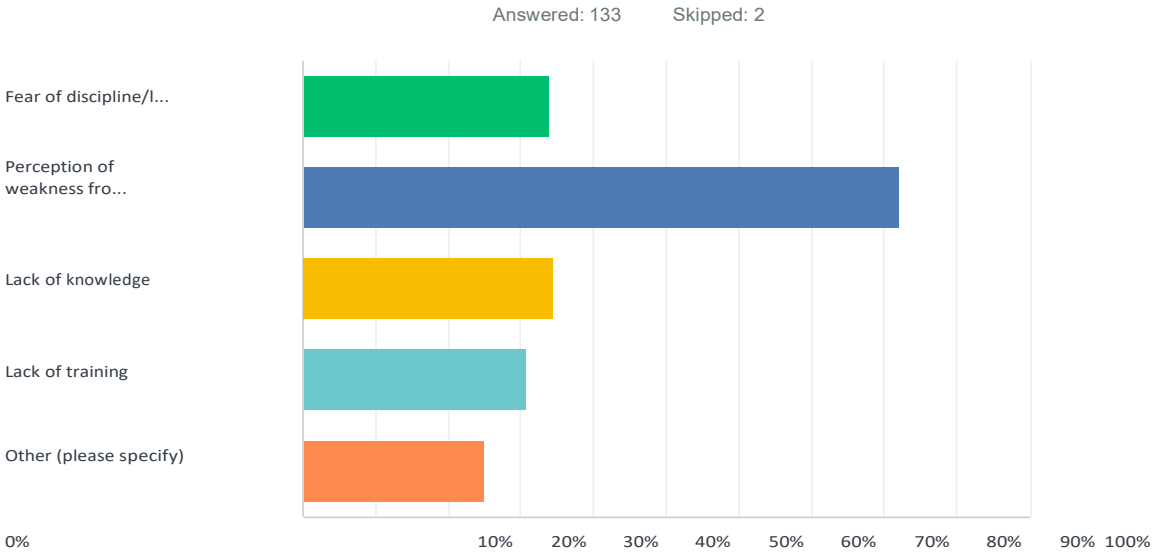
Third party counsler

Peer supporters; outside resources

refer to Peer support

EAP is useless when dealing with PTSD from this job. When the therapist is crying because of the stories, that’s a problem. We need specialists that understands our job. Much like a military therapist would understand the trauma of battle

Q11 What barriers exist that you feel may prevent those struggling with behavioral health needs from asking for help? Check all that apply



ANSWER CHOICES	RESPONSES	
Fear of discipline/losing job	33.83%	45
Perception of weakness from others	81.95%	109
Lack of knowledge about treatment options	34.59%	46
Lack of training about signs and symptoms of stress	30.83%	41
Other (please specify)	24.81%	33
Total Respondents: 133		

Showing 33 responses

Lack of caring about the issues that lead to this such as run volume, lack of downtime, OVERWHELMING amount of people that come to OUR firehouses after an incident

lack of concern from city leaders to fix the volume of runs and the lack of sleep for their most heavily burdened ems workers

I really don't think the city or department cares about the workforce in any departments of the city.

Personal reluctance only. DFD has not a tremendous job in creating a multitude of resources and stressing the importance as well as creating a positive atmosphere for seeking mental health assistance

Lack the willingness to be vulnerable and accept assistance

I do not feel there are barriers that exist

help is only available from peers to those in the " clicks."

lack of anonymity.

Personal Fear

Coworkers making fun of the member affected

Afraid to recognize symptoms and unwilling to take the steps to seek help.

No support from HQ or the City

The city not addressing the key issues- run volume and the amount of trauma seen daily. Until the city truly cares about the members and what they see and do, the culture will not change. Help for the officers also needs to occur; officers do not seek out assistance for fear of appearing weak to their subordinates. DC's and HQ chiefs need to reach put and care more for the officers- its currently a thankless job and more is being put onto their shoulders, that makes their job more stressful (Kronos, ESO.) The job used to be enjoyable and fun- it no longer is.

Lack of concern from leadership

pride

Apathy toward their own health and welfare.

a stigma that goes with getting help

I believe it is just human nature to try to fix these thing themselves. I believe the department has done a great job of pointing people towards resources. It's probably a time commitment thing. Most of us are so busy working other places or taking care of kids etc. etc..... that it's hard to carve out the time to take care of mental health

the city can provide empty words all they want, but they don't care about us

Can we find a way where one can submit anonymous complaints, questions or concerns about anything related to mental health/stress issues? Once questions are answered continue to converse with employee anonymously until he/she is ready to reveal themselves privately or publicly...

Use of sick leave appears to be taken personally by the DCs. You are threatened with being transferred, extra "time on the medic" as a punishment. And openly made fun of when you are

not there. It is a culture endorsed by the DCS.

private matters will no longer be private

confidentiality

I have heard guys say they would not talk to our peer support due thinking what they say will get out there for all to hear

Stigma. Lack of trust in confidentiality.

N/A
11/11/2019 8:03 AMAdd tags –View respondent's answers

May not recognize that they have a problem and can work through their issues on their own.

Perhaps they don't recognize the source of their depression or stress. Or don't see it in themselves.

unknown

Differences between EMS and Suppression

It's a self-awareness issue, as well. It's having PTSD recognizing you do, and then considering what options are available are very different things. It's always realized by the person affected. I don't believe most people who really have it realize they do. GG

Self-medicating, or the "I can deal with this on my own" mentality

Getting someone to admit they need help is the biggest struggle

Appendix B

National Behavioral/Mental Health Awareness Survey

Q1 Name of Dept (Optional)

Answered: 257 Skipped: 92

#	RESPONSES	DATE
1	KNOXVILLE FD	11/24/2019 12:36 PM
2	Sumter County Fire and EMS	11/23/2019 11:22 AM
3	WTFD	11/22/2019 6:43 PM
4	Wright Patt	11/22/2019 9:20 AM
5	City of Clayton	11/22/2019 7:23 AM
6	Perry Township Fire and EMS	11/21/2019 3:42 PM
7	Green Twp. Fire & EMS	11/21/2019 2:52 PM
8	Washington fire department	11/21/2019 11:38 AM
9	Washington Court House	11/21/2019 9:09 AM
10	City of Monroe	11/21/2019 7:57 AM
11	Minster Area Life Squad	11/21/2019 7:08 AM
12	German Township Fire and EMS	11/20/2019 9:23 PM
13	Washington Court House	11/20/2019 9:03 PM
14	West Carrollton	11/20/2019 7:30 PM
15	Med-Trans, Inc.	11/20/2019 4:16 PM
16	Ogden City Fire Dept	11/20/2019 12:41 PM
17	Benicia Fire Dept	11/20/2019 12:32 PM
18	Seaside Fire Department (CA)	11/20/2019 12:21 PM
19	Howard Fire Rescue	11/20/2019 12:11 PM
20	N/A	11/20/2019 12:08 PM
21	Miami Township Fire-Rescue	11/20/2019 11:06 AM
22	Wright-Patt AFB FD	11/20/2019 10:22 AM
23	Moraine Fire Division	11/20/2019 10:07 AM
24	Jackson Center Fire Department	11/20/2019 8:41 AM
25	Perry Port Salem Rescue	11/20/2019 8:15 AM
26	Bellbrook Fire Department	11/20/2019 8:03 AM
27	Bellbrook Fire Dept.	11/20/2019 7:58 AM
28	Box 21 Rescue	11/20/2019 6:22 AM
29	PPS Rescue	11/20/2019 4:24 AM
30	Mechanicsburg Fire Department	11/19/2019 10:20 PM
31	Xenia Fire Division	11/19/2019 9:03 PM
32	Bethel Township Fire Miami County	11/19/2019 5:37 PM
33	Fort Loramie	11/19/2019 4:22 PM
34	Piqua Fire Department	11/19/2019 4:21 PM
35	Fort Loramie Community fire company	11/19/2019 4:18 PM
36	Perry Port Salem Rescue	11/19/2019 4:05 PM
37	Beavercreek Township	11/19/2019 4:04 PM

38	Sidney Department of Fire and Emergency Services	11/19/2019 4:02 PM
39	SFRD	11/19/2019 3:56 PM
40	Miami Valley Fire District	11/19/2019 3:27 PM
41	n/a	11/19/2019 2:57 PM
42	Monroe Fire	11/19/2019 2:36 PM
43	Middletown fd	11/19/2019 2:19 PM
44	WTFD	11/19/2019 2:12 PM
45	Greenville Township	11/19/2019 2:04 PM
46	New Jasper Township Fire Department	11/19/2019 2:00 PM
47	Lewisburg Fire/EMS	11/19/2019 1:53 PM
48	Osgood Area Rescue Squad	11/19/2019 1:27 PM
49	Gasper Township	11/19/2019 1:08 PM
50	Los Angeles Fire Department	11/19/2019 1:07 PM
51	Prefer not to say	11/19/2019 1:07 PM
52	Springfield Fire Rescue Division	11/19/2019 1:07 PM
53	Trotwood Fire & Rescue	11/19/2019 1:03 PM
54	Rideg-Culver Fire Department	11/19/2019 12:46 PM
55	Overland Park (KS) FD	11/19/2019 12:25 PM
56	Burlington Fire Department (Vermont)	11/19/2019 11:49 AM
57	Frederick-Firestone Fire Protection District	11/19/2019 10:28 AM
58	Draper CIty Fire Department	11/19/2019 9:28 AM
59	Middletown	11/19/2019 8:30 AM
60	Sycamore	11/18/2019 3:34 PM
61	Moraine	11/18/2019 3:32 PM
62	Middletown Fire	11/18/2019 2:52 PM
63	Whitehall Bureau of Fire	11/18/2019 2:41 PM
64	Sand Springs (OK) Fire Department	11/18/2019 2:30 PM
65	Andover Fire-Rescue	11/18/2019 2:17 PM
66	Johnston-Grimes Metropolitan Fire Department	11/18/2019 1:46 PM
67	Seminole County Fire Department	11/18/2019 1:23 PM
68	Prince William Co (VA) Fire & Rescue	11/18/2019 1:18 PM
69	Independence Fire	11/18/2019 1:11 PM
70	Montgomery AL., Fire Rescue	11/18/2019 12:53 PM
71	Idaho Falls fire department	11/18/2019 12:51 PM
72	Bend Fire and Rescue	11/18/2019 12:47 PM
73	Zoneton Fire Protection District	11/18/2019 12:45 PM
74	Amarillo Fire department	11/18/2019 12:38 PM
75	South Area Fire and Emergency Response (SAFER) District	11/18/2019 12:24 PM
76	Gresham Fire & Emergency Services, Oregon	11/18/2019 12:11 PM
77	Bend fire and rescue	11/18/2019 12:10 PM
78	Middletown	11/18/2019 12:03 PM
79	Greenville Fire	11/18/2019 11:28 AM
80	Columbus (OH) Division of Fire	11/18/2019 10:50 AM

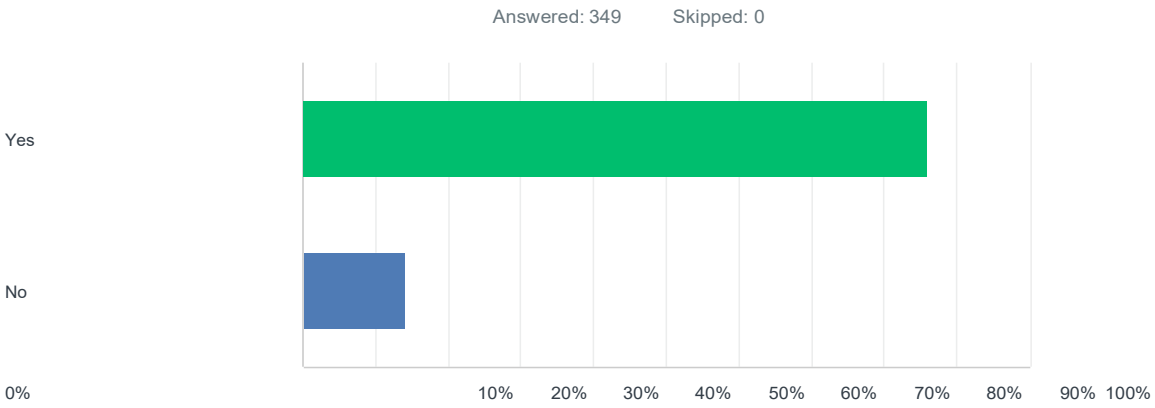
81	Little Miami Fire & Rescue	11/18/2019 10:06 AM
82	Upper Merion Township Fire and EMS	11/17/2019 10:35 PM
83	Sycamore township	11/17/2019 8:25 PM
84	Middletown	11/17/2019 7:23 PM
85	Middletown	11/17/2019 6:11 PM
86	Middletown	11/17/2019 6:10 PM
87	Middletown	11/17/2019 2:13 PM
88	Middletown	11/17/2019 1:21 PM
89	Reading Fire Department	11/17/2019 12:39 PM
90	Middletown	11/17/2019 12:31 PM
91	Middletown Division of Fire	11/17/2019 12:31 PM
92	Middletown	11/17/2019 12:07 PM
93	Matthews Fire & EMS	11/17/2019 10:52 AM
94	Middletown Fire Dept	11/17/2019 10:47 AM
95	Middletown Div of Fire	11/17/2019 10:40 AM
96	Bethel TATE Fire Department	11/17/2019 10:30 AM
97	N/A	11/17/2019 10:28 AM
98	Anderson twp	11/17/2019 10:19 AM
99	Sycamore Township	11/17/2019 10:01 AM
100	Ventura County Fire	11/17/2019 12:38 AM
101	Marion County Fire District #1	11/16/2019 11:00 PM
102	Sharonville	11/16/2019 7:02 PM
103	Sycamore Township	11/16/2019 5:20 PM
104	Sycamore Township	11/16/2019 1:43 PM
105	Mason	11/16/2019 12:50 PM
106	Pooler Fire-Rescue	11/16/2019 12:05 PM
107	Sycamore	11/16/2019 11:59 AM
108	Sycamoretownship	11/16/2019 11:53 AM
109	Kettering	11/16/2019 11:33 AM
110	Kettering	11/16/2019 11:33 AM
111	Akron	11/16/2019 11:20 AM
112	Sycamore Township Fire Department	11/16/2019 10:53 AM
113	Sycamore Twp	11/16/2019 10:36 AM
114	Sycamore Township	11/16/2019 10:26 AM
115	Colerain Township	11/16/2019 9:07 AM
116	Miami (Clermont)	11/16/2019 9:05 AM
117	Fire Department	11/16/2019 8:58 AM
118	Sycamore Twp	11/16/2019 8:30 AM
119	Sycamore Township	11/16/2019 8:29 AM
120	Sycamore Township	11/16/2019 8:24 AM
121	Sycamore township Fire department	11/16/2019 8:19 AM
122	Union Twp Clermont	11/16/2019 8:07 AM
123	Middletown Ohio	11/16/2019 7:46 AM
124	Metro Washington Airports Authority	11/16/2019 3:35 AM
125	Madison AL	11/15/2019 3:20 PM

126	Whatcom County Fire District No. 7	11/15/2019 1:46 PM
127	Caldwelll Fire & Rescue	11/15/2019 1:21 PM
128	Fremont Fire Department (California)	11/15/2019 1:11 PM
129	Meridian Fire Department	11/15/2019 10:55 AM
130	Ashburn VFRD	11/15/2019 9:19 AM
131	Chicago	11/14/2019 9:42 PM
132	Avondale Fire & Medical in Arizona	11/14/2019 9:07 PM
133	South Bay Fire Department	11/14/2019 8:33 PM
134	Kingston Massachusetts	11/14/2019 5:34 PM
135	Mountain View Fire Rescue	11/14/2019 3:20 PM
136	Millburn Fire Department	11/14/2019 1:52 PM
137	Apex Fire Department	11/14/2019 1:04 PM
138	Valdosta Fire Department	11/14/2019 12:17 PM
139	Springfield Fire Rescue Division (Ohio)	11/14/2019 8:39 AM
140	Shawnee Heights Fire district	11/13/2019 3:20 PM
141	Wyoming, USA	11/13/2019 1:13 PM
142	Round Rock Fire Department	11/13/2019 1:06 PM
143	Dixon Fire Department	11/13/2019 1:05 PM
144	Westbrook Fire Rescue	11/13/2019 12:52 PM
145	Myrtle Beach Airport Fire Rescue	11/13/2019 12:48 PM
146	Kings County Fire	11/13/2019 12:39 PM
147	Fond du Lac Fire Rescue	11/13/2019 12:18 PM
148	Nevada County Consolidated Fire District	11/13/2019 12:11 PM
149	Sandy Springs Ga Fire Rescue	11/13/2019 12:09 PM
150	Pinellas Suncoast Fire Rescue District (Florida)	11/13/2019 9:25 AM
151	Central Valley Fire District	11/13/2019 7:33 AM
152	Salem Fire Department (NH)	11/12/2019 4:25 PM
153	Riverside MO Fire Rescue	11/12/2019 3:33 PM
154	Pascagoula Fire Dept	11/12/2019 3:24 PM
155	Dallas Fire & EMS	11/12/2019 3:10 PM
156	Anchorage Fire Department	11/12/2019 3:01 PM
157	Englewood Area Fire Control District	11/12/2019 2:58 PM
158	Wooster Division of Fire	11/12/2019 2:54 PM
159	Portland (Maine) Fire Department	11/12/2019 2:18 PM
160	Rock Springs Fire Department	11/12/2019 1:56 PM
161	City of Snoqualmie, WA	11/12/2019 1:46 PM
162	Gastonia Fire & Rescue, Gastonia, NC.	11/12/2019 1:08 PM
163	Northern Lakes Fire Protection District	11/12/2019 12:58 PM
164	Fargo Fire Department, Fargo ND	11/12/2019 12:45 PM
165	Johnston-Grimes Metropolitan Fire Department	11/12/2019 12:40 PM
166	Goodyear Fire	11/12/2019 12:30 PM
167	Central Lyon Fire	11/12/2019 12:23 PM
168	Ridgefield, CT Fire Department	11/12/2019 12:23 PM
169	Carlisle Fire	11/12/2019 12:20 PM
170	King County Medic One	11/12/2019 12:17 PM

171	Springdale Fire	11/12/2019 12:16 PM
172	Grand Forks Fire Department	11/12/2019 12:15 PM
173	Clay Fire	11/12/2019 12:14 PM
174	Statesville Fire Department (NC)	11/12/2019 12:12 PM
175	Lake Ozark Fire Protection District	11/12/2019 12:12 PM
176	Washington Township Fire Department (Mont. Co. Ohio)	11/12/2019 12:11 PM
177	Rincon Valley Fire District	11/12/2019 12:09 PM
178	Sharon (MA) Fire Department	11/12/2019 12:09 PM
179	Lubbock FIre Rescue	11/12/2019 12:07 PM
180	Nestucca Rural Fire Protection District	11/12/2019 10:59 AM
181	Eagle River Fire Protection Dist	11/12/2019 10:53 AM
182	St George Fire Dept	11/12/2019 10:25 AM
183	Gwinnett County Fire and Emergency Services	11/12/2019 9:36 AM
184	Statesboro Fire Department	11/12/2019 9:32 AM
185	City of Eudora Fire & EMS Department	11/12/2019 9:26 AM
186	Little Rock Fire Department	11/12/2019 8:54 AM
187	Portsmouth Fire Rescue and Emergency Services	11/12/2019 7:31 AM
188	Two Rivers Fire Department	11/12/2019 7:27 AM
189	SPFR	11/12/2019 6:40 AM
190	Meriden Fire Dept	11/12/2019 6:13 AM
191	Baton Rouge fire Dept	11/12/2019 12:44 AM
192	Tulsa Fire	11/11/2019 9:53 PM
193	York County Fire	11/11/2019 8:44 PM
194	Lake Travis Fire Rescue	11/11/2019 6:59 PM
195	Johnson City Fire Department	11/11/2019 6:29 PM
196	Flint Hill Fire Dept.	11/11/2019 5:52 PM
197	Birmingham Fire	11/11/2019 5:37 PM
198	Akron	11/11/2019 5:28 PM
199	Prospect Heights (IL) Fire District	11/11/2019 5:16 PM
200	Hiawatha, Iowa Fire	11/11/2019 4:35 PM
201	Mid-County FPD	11/11/2019 4:09 PM
202	Maple Bluff	11/11/2019 3:38 PM
203	Colorado Springs (CO) FD	11/11/2019 3:37 PM
204	Norfolk Fire Rescue	11/11/2019 3:30 PM
205	Lynn Fire Department	11/11/2019 3:12 PM
206	Hastings Fire and Rescue	11/11/2019 2:54 PM
207	Bolinbrook	11/11/2019 2:50 PM
208	MACOMB Twp	11/11/2019 2:41 PM
209	Lincoln Fire & Rescue	11/11/2019 2:38 PM
210	DC FIRE AND EMS	11/11/2019 2:38 PM
211	Virginia Fire Department	11/11/2019 2:37 PM
212	Fire Dist #1 of Johnson County	11/11/2019 2:31 PM
213	Harrisonburg Fire Department	11/11/2019 2:23 PM
214	Fayetteville Fire N.C.	11/11/2019 2:15 PM
215	New Hartford Fire	11/11/2019 2:01 PM

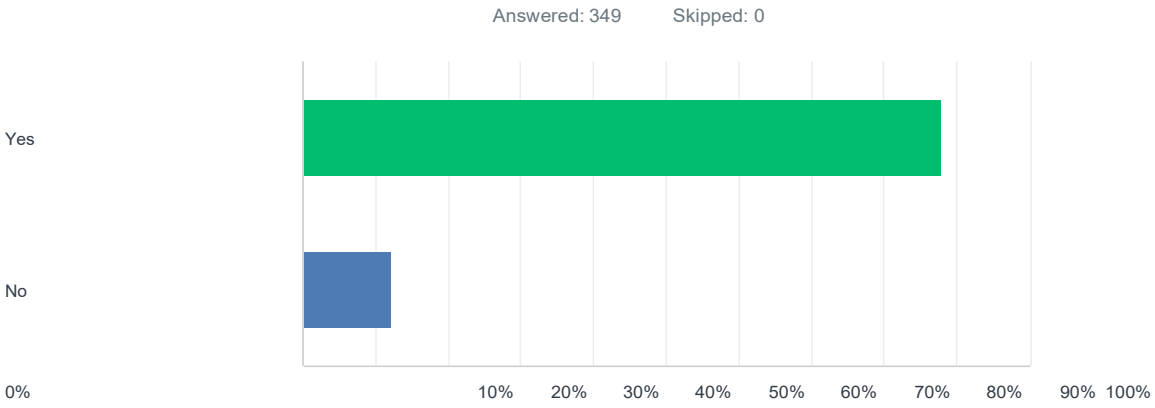
216	Phoenix Fire Department	11/11/2019 1:59 PM
217	Aurora fire rescue	11/11/2019 1:58 PM
218	los angeles county	11/11/2019 1:54 PM
219	Bedford NH Fire Department	11/11/2019 1:46 PM
220	Cambridge, MA	11/11/2019 1:43 PM
221	Riverside mo Fire	11/11/2019 1:37 PM
222	Anchorage Fire Department	11/11/2019 1:21 PM
223	Telluride Fire Protection District	11/11/2019 1:17 PM
224	Clearcreek Fire District	11/11/2019 1:09 PM
225	Lubbock Fire Rescue	11/11/2019 1:04 PM
226	Grand Junction Colorado	11/11/2019 12:56 PM
227	Cardinal joint fire district	11/11/2019 12:51 PM
228	Hilltop Fire District	11/11/2019 12:44 PM
229	Montgomery County ESD #8	11/11/2019 12:34 PM
230	Aberdeen Fire Rescue	11/11/2019 12:33 PM
231	Kissimmee Fire Department	11/11/2019 12:33 PM
232	San Diego Fire-Rescue Department	11/11/2019 12:27 PM
233	Las Cruces Fire Department	11/11/2019 12:27 PM
234	Verona Fire Department	11/11/2019 12:23 PM
235	Eugene Springfield Fire	11/11/2019 12:21 PM
236	Stafford County Fire & Rescue	11/11/2019 12:20 PM
237	Hartsdale FD	11/11/2019 12:19 PM
238	Seattle Fire Department	11/11/2019 12:18 PM
239	Indianapolis	11/11/2019 12:16 PM
240	Westminster FD, Colorado	11/11/2019 12:15 PM
241	Westampton Township	11/11/2019 12:15 PM
242	Broward	11/11/2019 12:13 PM
243	McAllen Fire Department	11/11/2019 12:12 PM
244	Coral Springs-Parkland Fire Department	11/11/2019 12:10 PM
245	Prince William County Department of Fire and Rescue	11/11/2019 12:09 PM
246	Richmond Fire Department	11/11/2019 12:08 PM
247	Henrico County (VA) Division of Fire	11/11/2019 12:08 PM
248	Scott Township Fire & EMS	11/11/2019 12:08 PM
249	Decatur Fire	11/11/2019 12:07 PM
250	Defiance, OH	11/11/2019 12:07 PM
251	Golder Ranch Fire District	11/11/2019 11:39 AM
252	Los Alamos	11/11/2019 11:34 AM
253	Sandoval County Fire and Rescue	11/11/2019 11:25 AM
254	Helena Fire Department	11/11/2019 11:13 AM
255	Greenville Fire/Rescue	11/11/2019 10:58 AM
256	Platte Valley Fire District	11/11/2019 10:57 AM
257	DFD	11/11/2019 9:23 AM

Q2 Are you presently aware of the mental/behavioral health treatment options available to you as a member of your Department?



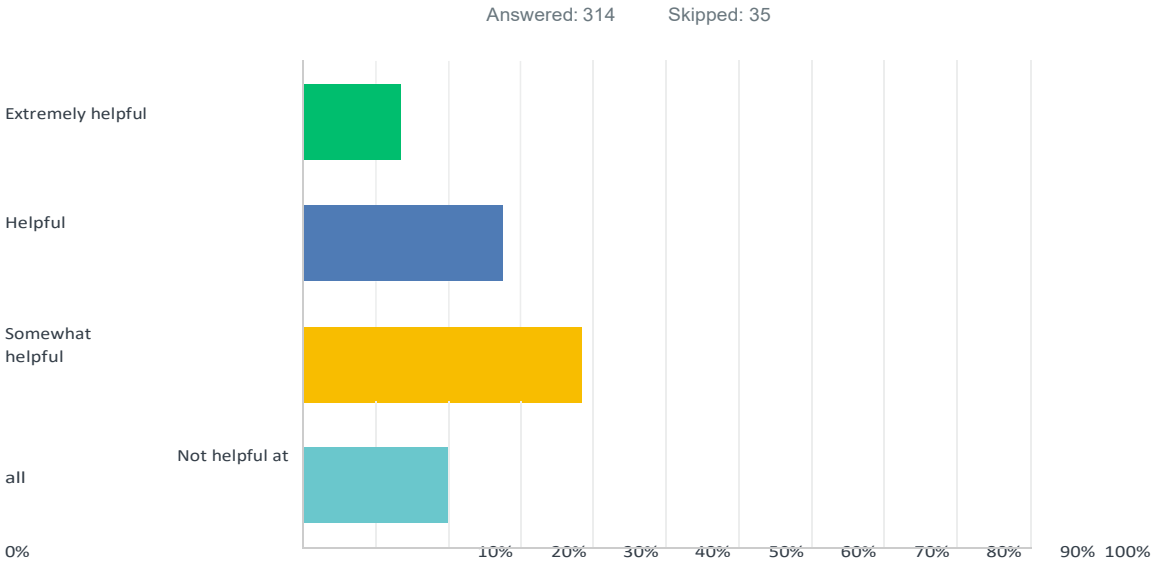
ANSWER CHOICES	RESPONSES	
Yes	85.96%	300
No	14.04%	49
TOTAL		349

Q3 Have you ever participated in a critical incident stress debriefing (CISD) after a traumatic event?



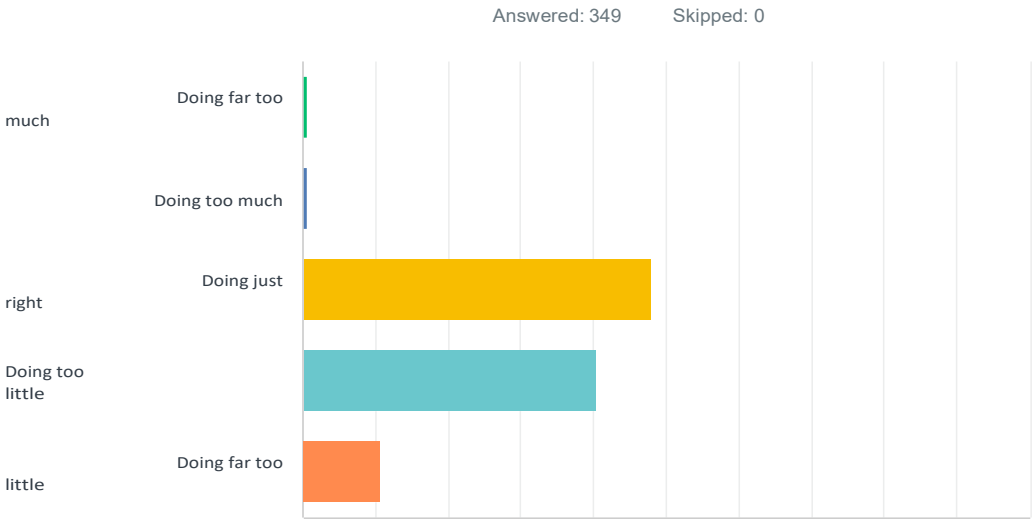
ANSWER CHOICES	RESPONSES	
Yes	87.97%	307
No	12.03%	42
TOTAL		349

Q4 If you answered yes for question #3, Did you find the critical incident stress debriefing helped to eliminate or reduce your stress related to that event?



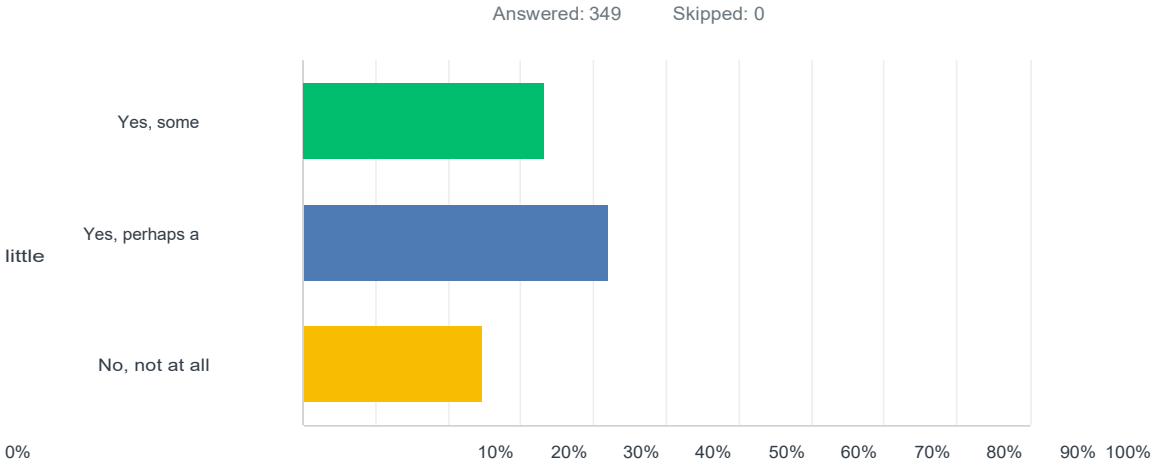
ANSWER CHOICES	RESPONSES	
Extremely helpful	13.69%	43
Helpful	27.71%	87
Somewhat helpful	38.54%	121
Not helpful at all	20.06%	63
TOTAL		314

Q5 Regarding mental health awareness, how would you say your department is doing to address the mental/behavioral health needs of its employees?



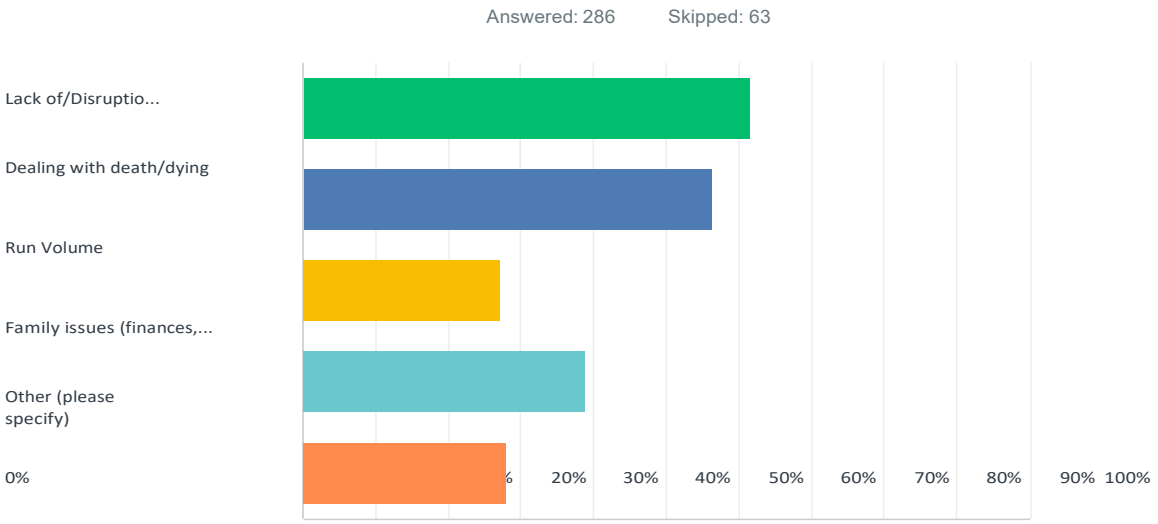
ANSWER CHOICES	RESPONSES	
Doing far too much	0.57%	2
Doing too much	0.57%	2
Doing just right	47.85%	167
Doing too little	40.40%	141
Doing far too little	10.60%	37
TOTAL		349

Q6 Do you feel or have you ever felt that you have PTSD as a result of your occupation?



ANSWER CHOICES	RESPONSES	
Yes, some	33.24%	116
Yes, perhaps a little	42.12%	147
No, not at all	24.64%	86
TOTAL		349

Q7 If you answered yes to question #6, what do you attribute as a leading cause of that stress? Check all that apply



ANSWER CHOICES	RESPONSES	
Lack of/Disruption of sleep	61.54%	176
Dealing with death/dying	56.29%	161
Run Volume	27.27%	78
Family issues (finances, spouse, etc.)	38.81%	111
Other (please specify)	27.97%	80
Total Respondents: 286		

Showing 80 responses

Politics of the job!!!

None

Tones/speakers too obnoxiously loud.

on and off work traumatic experiences including death and death of a family member

Constant calls for non-emergency Issue.

General Stress of the job

N/A

Department concerns that are out of my control (e.g., city politics, budgeting decisions, etc.)

Workload

N/A

A few particular incidents that have stuck in my head, some for about 25 years or so: I find I will wake up in the night replaying in my dream a particular scene of an incident, over and over nothing changes. It doesn't cause me concern; it just is what it is. Another thing that doesn't help is living in the community I work in. As I drive around town I am constantly reminded of past incidents. I don't see me living here in retirement for that reason.

critical patient

Specific Traumatic Events

Work environment/poor leadership

Understanding how to develop resiliency to the insults.

moody

NA

My full-time non-EMS job and conflict with my department. Health Issues. What I have seen on calls, & everyday stress (money, bills, dr appts, etc.)

Quantity of calls vs. too few volunteers

Political/Administrative

I didn't answer yes

co-worker ego and time away from family

Department personnel

Combination of various calls

Pay

Memories of the incident

Constant threat of job loss from trustees and township administrator

Depression, anxiety

Lack of Admin support

NA

Period in life specific

Exposure to Traumatic Event - Recurring thoughts

I think it is culmination of all of the items listed above

Clientele abusing the system

years of doing the work we do

Specifically small child

the stress of staying at the top of my game, the stress of every action being under microscope, the stress of watching others get picked on for not being just like the others guys and only being able to do so much about it

Close to home

Compounded on top of military experiences

N/A

past experiences, growing up

Specific calls

Answered no

General societal issues, increase in amount of people dependent on gov services,

Empathy towards others

N/A

Just don’t want to be a firefighter anymore. It’s been 30 years already

Na

Hazing

Injuries

No

The combination and lack of a way to contribute without continuing to have exposure to the stress of death, injury, exposure-related health concerns. While some department talk about bagging gear after a fire I'm in a medic unit making a medical run still in contaminated fire gear.

lack of education and awareness

Physical health, outside job stress

Dealing with the daily violence we see to include death of young children. And the violence against us as first responders

We are creating stereotypes, with an us and them mentality leading to unfairly judging people.

I answered no to #6, but I am required to answer this question

History of not dealing with bad calls together as a crew and management not inquiring or even knowing about a bad call.

administrative work stressors

Working through a broken process that does not specialize in first responder related issues.

Suicide of a co-worker, cumulative over years, poor leadership.

Military Vet

Trauma to members of the public served often caused by poor decision making due to lack of education or resources.

cumulative stress

Before any type of help was being offered.

Answered no

Cumulative Stress

N/A

Situations of the calls (active shooter)

Death of family members

A cumulative effect.

Political Pressure

N/A

Part of all the above items.

N/A

Stigma of PTSD in fire service culture at the time

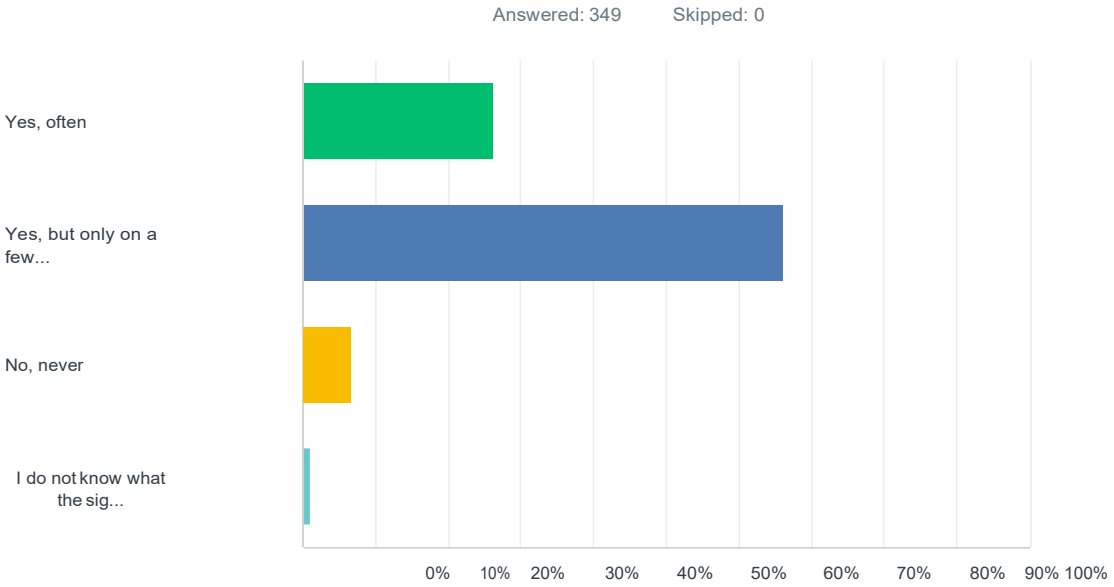
40+ years of seeing trauma, death, and victims grief.

N/A

Anger issues from time to time. Recalling the event after something has sparked the memory.

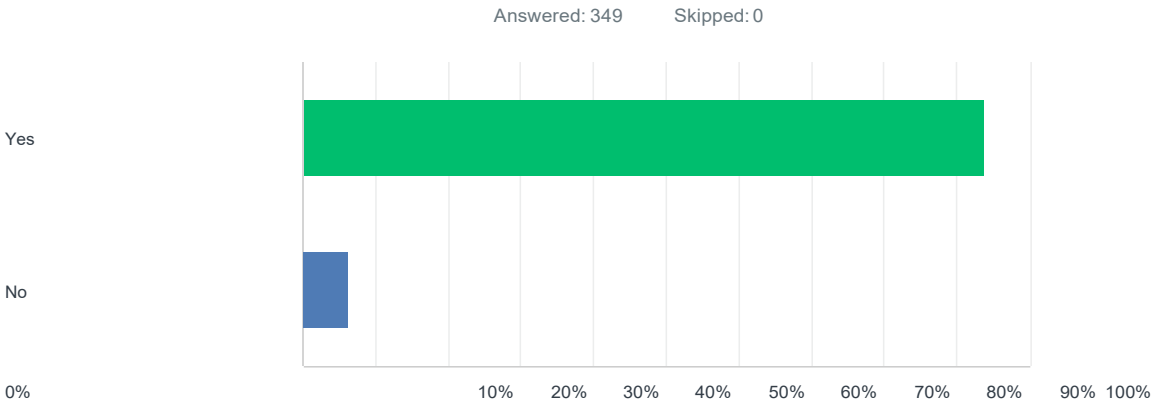
Close calls

Q8 Have you worked with co-workers whom you suspected were dealing with or displaying signs of PTSD?



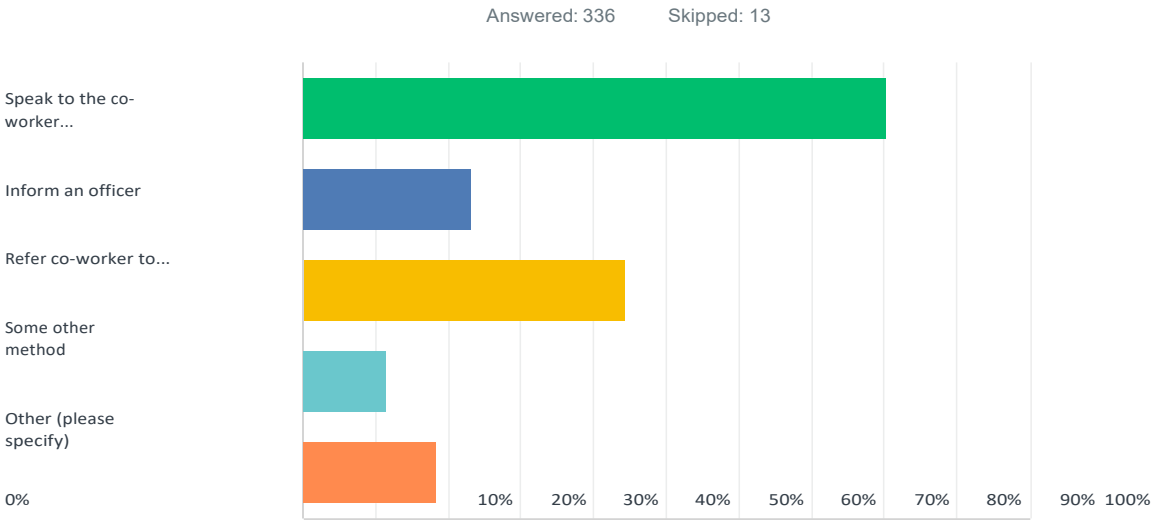
ANSWER CHOICES	RESPONSES	
Yes, often	26.07%	91
Yes, but only on a few occasions	66.19%	231
No, never	6.59%	23
I do not know what the signs of PTSD are	1.15%	4
TOTAL		349

Q9 If you suspected that you or a co-worker were suffering from PTSD, depression, or some other behavioral health issue, would you try to seek help or get help?



ANSWER CHOICES	RESPONSES	
Yes	93.70%	327
No	6.30%	22
TOTAL		349

Q10 If you answered yes to question #9, how would you most likely try to help another?



ANSWER CHOICES	RESPONSES	
Speak to the co-worker directly	80.36%	270
Inform an officer	23.21%	78
Refer co-worker to EAP confidentially	44.35%	149
Some other method	11.61%	39
Other (please specify)	18.45%	62
Total Respondents: 336		

Showing 62 responses

Wife is a mental health professional. I could get direction from her

IAFF Center of Excellence

Dept. has staff IAFF peer counselors that we can reach out to assist with getting help for any employee.

I would simply reach out and offer to get them some help, not sure how far I would force the issue.

employee assistant program

refer to peer-support

Dept peer support program

I feel it is the officers responsibility to identify this in their subordinates

Peer counseling

Contact our Behavioral Health staff

EAP doesn't work

utilize our peer support system

Through the use of our on staff Mental Health Counselor or our Peer Support Team

We have a local Chaplin corps with great relationships.

Ask our Chaplin to check in on them

Refer them to the UCF Restores Program

Peer Support

We have developed a Peer Support Group.

Contacted Peer support

refer to peer support

Department Chaplain or Local CISM team

Refer to center of Excellence

Eap is a total waste of time. I am currently being treated at a out pt facility

Peer counselor

Na

Refer to EAP or our in house psychiatrist

We have a contract with licensed professions in the mental health field.

Chaplain referral

In state PTSD referral resources

refer them to our department funded psychologist

Ensuring that our members have access to the “Right type of Mental Health Professionals”

Refer to Peer Support Member

Notify CISM team leader

Refer to Chaplain

Talk with those closest with the individual

Case by case as not every scenario or person is the same

Peer support

Refer them to our Peer Support program

Refer them to our Peer Support Team

family or friend

Reach out to our psychologist to reach out to the employee

Peer Support and possibly clinician reference

Chaplain

Iaff center of excellence

We have a lot of different resources.

Talk with a member of our peer support group on how to best approach the individual

all of the above

I have access to mental health professionals who are and have been first responders. I believe they do a better job than the contracted EAP. In addition, if they can't help they know who to refer the person to.

Peer support

Use our peer support team.

Speak to them and than inform my officer.

Use the Peer Support Team and an identified mental health clinician with specific experience in working with public safety officers

Refer to peer support

Refer directly to identified mental health professional with cultural competency in emergency services.

Peer support team and/or CISM team

Refer to Department peer support team

SDFD has a substantial behavioral health program, I would reach out to them and they would approach the individual with a clinician, peer support or Chaplin.

Refer to Peer Support Group

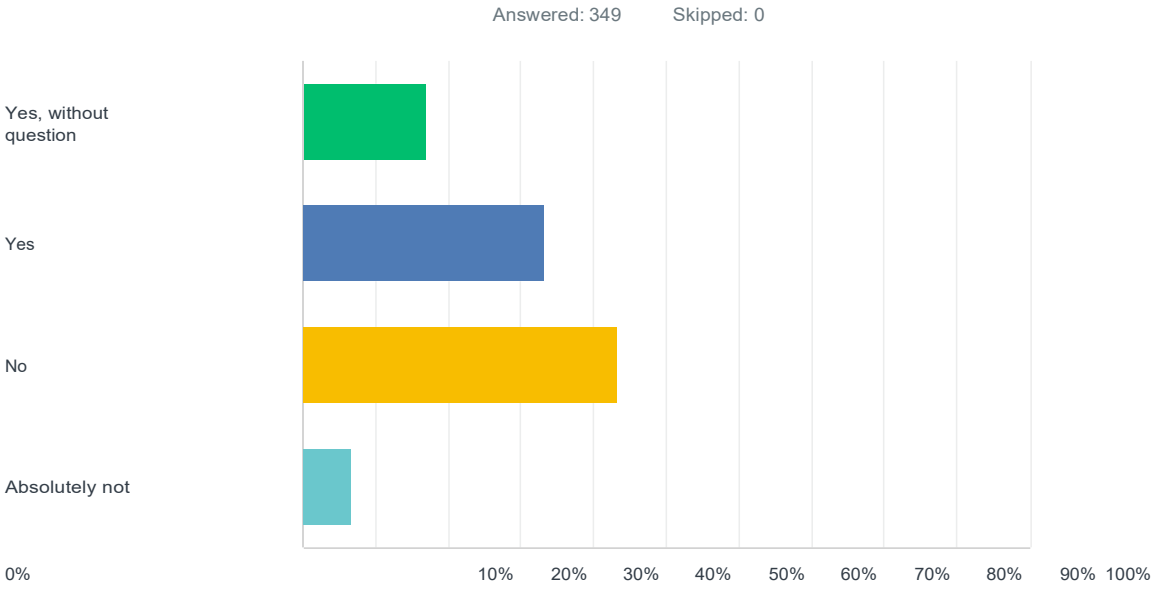
We have a member's assistance program

Refer to peer support or FD Clinician Response Team (CRT)

Chain of command or find a peer to assist

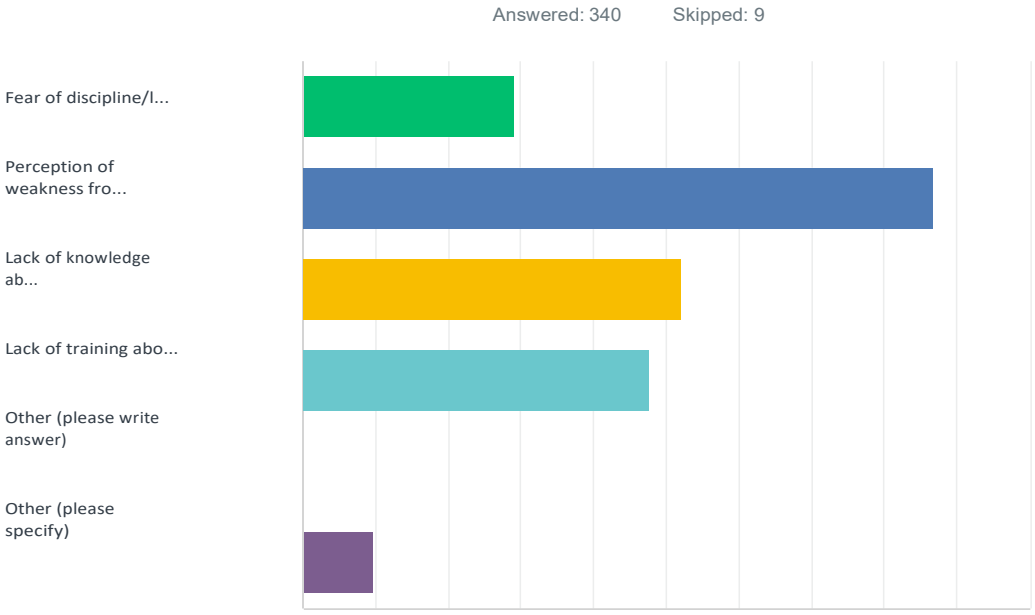
Chaplain w/ ptsd training are available

Q11 Do you feel that there is a culture within your department that prevents members from asking for help for their emotional or psychological needs?



ANSWER CHOICES	RESPONSES	
Yes, without question	16.91%	59
Yes	33.24%	116
No	43.27%	151
Absolutely not	6.59%	23
TOTAL		349

Q12 What barriers exist that you feel may prevent those struggling with behavioral health needs from asking for help? Check all that apply



ANSWER CHOICES	RESPONSES	
Fear of discipline/losing job	29.12%	99
Perception of weakness from others	86.76%	295
Lack of knowledge about treatment options	52.06%	177
Lack of training about signs and symptoms of stress	47.65%	162
Other (please write answer)	0.00%	0
Other (please specify)	9.71%	33
Total Respondents: 340		

Showing 33 responses

Prideful

I think there could be a general embarrassment that it won't be forgotten and therefore, brought up in the future. Not so much a weakness but embarrassment.

fire service mentality

Cost of insurance coverage for treatment

embarrassment, unsure they need help, the distance to immediate help.

denial of issues

Not believed by the City or Workers Comp

There are no barriers

Previously a Chief's opinion on Stress Debriefing. They stated they didn't want to sit around holding hands and singing a specific song.

assuming this is a normal response, and I'll get over it.

Funds

No EAP or other services available to employees

Made fun of by the chief

Perception of weakness in themselves.

Denial of sign and symptoms

Fearful of management viewing it as a character flaw, influencing the potential for promotion.

Fear of being seen as incompetent

Lack of support from our city management and a complete failure of support at the state level from our Union reps and the governor himself. To the extent that fireman are not allowed PTSD. The cops can have and get retirement because they carry a gun and deal with the dead. Last I knew fire is the ones who have to deal with them when they're dead, dying, or screaming at the top of their lungs. We also have to deal with the families grief and inform them there's nothing we can do.

Lack of care by city leaders

The belief that he/she can handle the issues on their own.

No one will actually do anything for fear of a lawsuit for accusations the person will deny.

fear of reprisal in the form of promotional exams, ignorance on the part of the department

All listed answers are part of the cultural stigma

It's starting to change as we educate, and more people start to speak out.

Culturally we have accepted the benefits of resiliency training

Financial ability to obtain treatment.

Not aware of all resources available

Time out of day to do so

Lack of trust with mgt

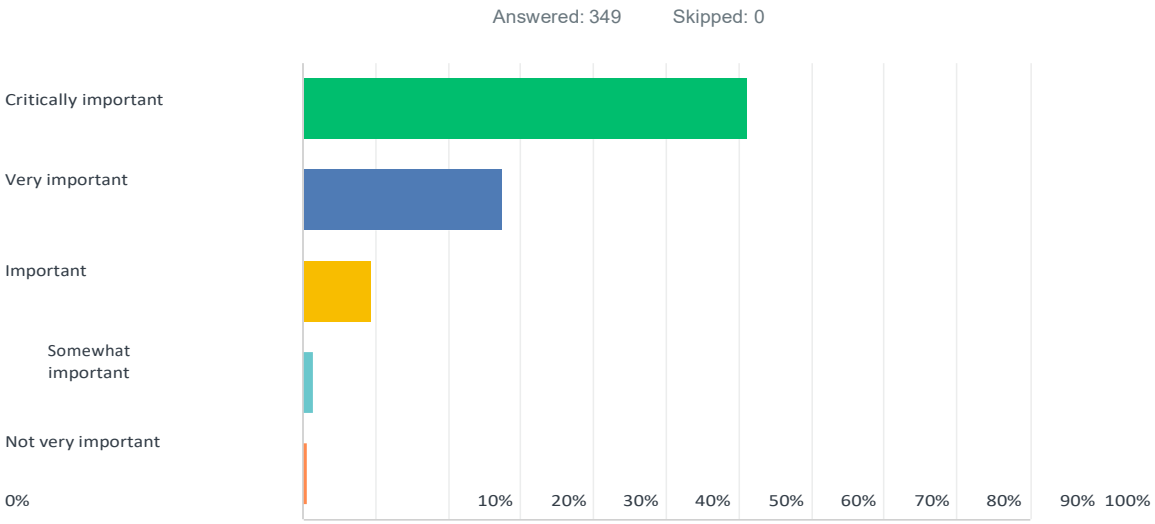
All of the above

Resources are available; individuals need to take some responsibility as well to seek help

There are no agency barriers.

Individual feeling that they 'can handle this'; available time it may take;

Q13 First responder suicide is ____issue for the fire service.



ANSWER CHOICES	RESPONSES	
Critically important	61.03%	213
Very important	27.51%	96
Important	9.46%	33
Somewhat important	1.43%	5
Not very important	0.57%	2
TOTAL		349

Appendix C

Kettering Behavioral Medicine Center-Clinical Program Manager Julie Manuel Interview

Fire Headquarters

November 26, 2019

Jeff: Thank you for your willingness to participate in this research. Obviously, 2019 was a very difficult year for the City of Dayton and the DFD with the HSK (KKK) rally, the F4 tornadoes, a mass shooting, the double fatality vehicle accident involving children, and the suicide of FF Poole. Because of your role with providing CISD and behavioral health counseling services to some of our members, I wanted to ask you if you have found our members to be hesitant in talking with you regarding their mental health concerns?

Julie: Yes, and no. Just prior to the mass shooting I had been talking with a variety of other departments to determine what barriers were present, why are we not getting some of these folks? Over the last two or three years, I had been working with a lot of the union members to see how I, as a provider, get on the inside so that we can try to assist some of these folks from having some of these same issues that we continue to see. Not just from a personal standpoint, but from a professional standpoint, seeing folks that come in that really deal with their trauma after the fact, and didn't deal with it before because they didn't know, didn't know what to do. So for several years, I've really been working on how do we get it? What do we do? So I developed a survey with our EMS coordinator within the Kettering Network and sent that out to 26 departments. We sent it out on August 2, 2019, and within hours, I had received 12 back. Once the shooting occurred, nothing. Crickets.

I think that people were fearful, and so we reconvened to determine, "why did this happen?" I think the big reason is because people are scared. Initially, when the shooting happened, and we opened up the union hall and had a very laid back, come out and chat if you want to, we had several people that did that. If they knew that they were by themselves, everything was fine, but the minute there was someone else that pulled in, they were like, "Oops, I gotta go." Because there was this fear of what is the perception going to be of me being here, chatting.

We had the spousal event with an okay turn out, but not great because I think the fear of the perception of asking for help.

Jeff: What kind of turn out did you get for those events?

Julie: We saw about 22 at the individual support sessions, of which we sent five individuals on for more intensive therapy. We did a total of 15 group sessions, and I would say, on average, out of the 15, I would say 2 to 5 people would seek more help.

After Brian (Poole), I think people felt a little better with talking. I think knowing my face, having that comfort level, I had many more who were willing to talk to me.

Several of the members would say that they were worried about their jobs. Many of them said, "what if the chiefs find out?" I would explain to them that your command staff is really leaning into the mental health awareness, behavioral health services, so I think it is more about a "buy-in" approach from them. I think that your peer support team is vital and critical for that, but they must have the same belief that your command staff is very on-board with this. Everyone is on

the same team; we are all on the bench together trying to figure out what is the best play for our team?

Jeff: You have been in this a long time and have obviously dealt with other departments and other professions, are you finding the fire service to be different or the same as others when it comes to their willingness to speak about mental health?

Julie: The fire service is different because I think that the fire service is here to serve others and so the perception is that "we are the ones that are going to run into the burning buildings" I've heard it repeatedly, "we are the heroes," "we are not supposed to be weak, to cry, or show emotion." when in reality, that is exactly what is healthy, and what we have to do. Interestingly, since starting the intensive outpatient services at Kettering, we have seen a variety of different professions. We've seen attorneys, teachers, doctors, and even psychiatrists. Many organizations are placing more priority on educating their employees about work-life balance, creating better-coping skills, greater self-awareness, and the use of available mental health resources. Unfortunately, they too have fears about people finding out with a common theme of "what will the perception be if I am seeking mental health treatment? "

I don't know so much that it is a weakness, but it's more about the stigma about receiving services.

Jeff: Describe your intensive outpatient treatment program

Julie: It is a 6 to 8-week program, 10 hours each week. We have two mental health programs currently and a co-occurring or dual diagnosis program. Our plan is start a PTSD specific program for first responders because it is an entirely different type of service that we have to provide.

Jeff: Are there any other barriers that are preventing people from seeking behavioral health services?

Julie: A couple things, one, the stigma of receiving mental health services has really impacted our society at large. Historically speaking, if you had a mental health issue, you were sometimes literally locked in chains and treated extremely poorly because we just didn't know. Of course, knowledge is power, and we have evolved over time, but the stigma of if I have depression, or if I have anxiety, if I have a personality or

bipolar disorder, I think that people are fearful of "what will others think of me if they know?" So stigma is definitely a barrier.

I also think, when it relates to trauma, I think that people are just used to compartmentalizing, so much so, that they don't know. So maybe an education barrier? Witnessing trauma daily on the job, but I think from an education standpoint, it is vital and critical that we de-compartmentalize that type of behavior. Pushing all of the traumas that first responders see each day into little compartments is probably a very big barrier that people have run into.

Jeff: What role do you think our culture plays into that?

Julie: I think it's a historical problem. That's just how you were taught. From rookie class all the way through each promotion.

Jeff: Does that culture legitimize that thought? To compartmentalize everything?

Julie: Absolutely. I've had conversations with many of your members who said, well others before me saw a lot of bad things, and they never got help, and my response is often, yes, but do you know how many divorces they have been through, or how many OVIs they might have had? How many alcohol and drug treatments have they been through? We have to look at what were the self-destructive behaviors they were utilizing to cope with the trauma they were dealing with.

Jeff: Do you see a lot of co-occurring or dual diagnosis in the fire service?

Julie: Yes. I would say, healthcare workers, fire service, law enforcement, dual diagnosis, co-occurring disorders are incredibly prominent. Incredibly.

Jeff: So PTSD and depression, or substance abuse?

Julie: Yes.

Jeff: Is substance abuse the most common?

Julie: Yes, the self-medication attempt to help cope with the trauma. It is so prevalent.

Jeff: As a result of 2019, the DFD has become more forward-leaning lately when it comes to mental health awareness. Are other professions ahead of recognizing the mental health needs of their employees?

Julie: Well, I think certainly the military has been on this track for several years, but unfortunately with the VA, and the type of services available to them, it becomes quite a challenge. They have their own unique barriers that they are trying to get through as well. There are multiple departments that we know of or universities that I've talked with that have implemented some interesting things, IOP programs, peer support programs, sensory mindfulness grounding relaxation within the houses. Service dogs, emotional support animals within the department, things like that.

But I would say that the majority of those departments have had some catastrophic events. A good example is Denver, with many shooting events. They have some really good programs out there. The University of Florida is doing a lot with the Pulse nightclub shooting as well. FDNY after 911 also implemented a lot of programs.

Jeff: Do you think the term PTSD is overused or too broad? And do you fear that PTSD has become the "dirty helmet" of the fire service, where members feel that if they don't have it, then they have not done much?

Julie: PTSD is unique in that not everyone gets it. It is not a cold where if someone sneezes, everyone gets it. Some of us are more resilient than others; some of us have better-coping skills, even before we witness these tragic things. Do I think the term PTSD may be too broad, yes? A lot of times, when I am speaking, I leave PTSD out and say trauma-related events because everyone reacts differently. I would agree, it's kind of like the dirty helmet, like, well if you have it, then I should have it, well that's not necessarily true, and it's not a bad thing if you do or you don't. It is what it is, and knowledge is power. So, if we can educate people on, you may not have 10 of the symptoms, but maybe you have one. Does that mean you have PTSD, no, it just means that maybe you need to talk about things that are going on or work to develop your coping skills.

Jeff: What will it take for the fire service to strip away the stigma of asking for help for their mental health? Does it take another 911?

Julie: Sigh. I hope not. My fear is yes. My fear is unless we are able to truly educate the members, it will continue until we have more and more tragic events until a member's bucket overflows. But, I am hopeful that if we can get within the departments and have that liaison that is trusted and is the face of a movement that is able to talk about it freely and openly with the members. I think it could start to change faster.

Julie: Recently, I attended a peer support meeting, and I left feeling a bit disheartened because the camaraderie of the peer support team has to be a group effort, and everyone has to be on board. Everyone has to believe that the command staff, the leaders, the union are all on board. Also, having the ability to educate the peer support members is critical for success.

Jeff: Is mental/behavioral health too important to relegate to the peer support team? Do they have the necessary knowledge, skills, and abilities to handle it?

Julie: The peer support team is critical, but they do need a liaison that is able to provide a more clinical insight into behavioral health and behavioral health services because, unfortunately, we are very reactionary and will wait until something else happens. Then we will call someone in and educate our members when we should have been doing it all along.

Jeff: What are your thoughts on the value of CISD after large events?

Julie: I think they can be very positive or very negative. If they are run properly, they can be extremely effective. Sometimes, it becomes kind of a war story thing, and we tend to re-victimize and re-traumatize people when we come into these briefings because we don't know exactly what to say.

Jeff: You've mentioned the need to have coping skills such as exercising, volunteering, etc. Because of our run volume and disrupted sleep patterns, our members may not feel like doing those things, do you feel that these too may be barriers that are preventing our members from being more proactive to their mental health needs?

Julie: Absolutely. We have had a lot of members reach out. Many were very reluctant at first to even mention that they were first responders.

Jeff: Is it possible to cure PTSD?

Julie: You can un-see, but you can unlearn the cues and the triggers for your particular trauma. Is it curable? That is debatable; I would say that it is treatable.

Jeff: If you had to take an educated guess regarding the percentage of DFD employees that may have PTSD, what would you guess?

Julie: I would say well over half of the department.

Jeff: Is the department's peer support team enough to address the potential problem?

Julie: I think the peer support team can change things, and I know that they are completely dedicated and that they want to help. They want to be part of this, but I think it is a little bit bigger than what they can provide at this point with the skills that they have.

Jeff: And this is too critical to get this wrong…

Julie: Because what will happen is there will be cascading events.

Jeff: Across the country, the fire service has really pushed peer support as a solution to address the mental health awareness of its members, can they do it alone?

Julie: Again, they have the ability to do so much, but I feel like they alone do not have all of the skills necessary to handle the gravity of the situations that often occur after tragic events.

Appendix D

Firefighter James Moe Interview

Fire Station 18

November 15, 2019

Jeff: I want to thank you for taking the time to meet with me regarding mental health awareness in the Dayton Fire Department (DFD). I will go ahead and start.

Jeff: How long have you been with the DFD?

James: Started December 18, 2006, so thirteen years this December.

Jeff: And you have military experience before that?

James: Yes

Jeff: Have there been incidents in your career that you thought that may have affected you or perhaps lingered long after the incident?

James: Absolutely, one in particular, well, there is two. In Maryland, they don't only treat substance abuse. They treat mental issues as well and two of those incidents where those kids died affected me and still do.

Jeff: When you refer to Maryland, are you referring to the IAFF Recovery Center?

James: Yes. It is a behavioral and mental health/substance abuse treatment center.

Jeff: Ok, and how long were you there?

James: Thirty-four days, in-patient.

Jeff: And what type of treatment did you undergo?

James: Counseling, individual and group classes, around the clock

Jeff: Were you clinically diagnosed with PTSD there?

James: Not there, before that by a family doctor.

Jeff: How long ago if you don't mind me asking?

James: When I got back from Kosovo so, 2004, 2005.

Jeff: So then, the things you witnessed in Kosovo, is that where the PTSD stemmed from?

James: A little bit there, being away for the holidays, just being away, a girlfriend cheating on me while I was there. That all together sort of…we carried over 200 rounds of ammo on us with an m16. It got so bad that there wasn't honestly a day that went by that I didn't think, Wow, I've got 210 rounds of ammo on me because it was

so hard to deal with everything over there. I mean even, just missing my birthday or Christmas, it was terrible.

Jeff: Going back to Maryland and the treatment center, you mentioned the death of those children, were you harboring some feelings because of that?

James: It was on the EMS side, stuff I witnessed here at work on the medic, we discovered in Maryland how it had affected me and was affecting me because I had been masking the issue with drugs and alcohol for so long that I didn't have feelings, so I didn't really know the root of those feelings.

Jeff: How did they boil down, or get down to that level for you to discoverer the root of the pain?

James: Seven days pretty much of intense psych therapy they call it. You start out with ten events that might have happened and the keep narrowing it down, narrowing it down until they find the one or two that sting the most, and they go with that.

Jeff: Did you find that identifying the cause was helpful?

James: yes, very much so

Jeff: How so?

James: Well, I am drug and alcohol-free now for the last six months. Like I said, before I masked everything with drugs and alcohol, not even thinking, just get off work, and get drunk, not talk about my issues because I didn't know how to talk before I went to the recovery center. I buried it down deep.

Jeff: Do you think outside of the firehouse that anyone knew what you were carrying around with you?

James: Severe anger. Unknown outbursts, ticking time bomb is how I was always referred to. Every relationship I have ever had since I became a FF has been ruined because of my attitude, anger, drinking, something related to the stuff I have seen because I hadn't talked about it and hadn't got help.

Jeff: Did anyone ever ask you if you needed help? Did anyone notice?

James: Girlfriends noticed. They didn't know I was hiding a pain medication problem, but my drinking had gotten out of control; you are always yelling, always mad but nothing ever came from it.

Jeff: Was there ever a time where you identified, I need some help?

James: Yes, that is when work came into play.

Jeff: Were there barriers at work that made you sensitive about asking for help or seeking help?

James: Well, yes, everyone knows that you don't want to be a pussy. I mean, especially hearing stories from my dad, you were looked down upon even if you wrote up an injury report. I still hear people getting dogged for writing up injury reports. You don't want to be that guy; you want to feel like a man, you don't want to be weak. You don't want to go cry. The Fire Department is really tough love. They get this; I don't know.

Jeff: Do you think that the fire department culture is getting better towards understanding the mental health issues?

James: Absolutely

Jeff: What are some of the changes that you have noticed?

James: Everyone knows that we have had a hell of a year, the peer support group has been coming around for everything; that is the first time I have seen them.

Jeff: Do you ever feel like we are doing too much?

James: I think there is a benefit just because what I went through. The problems go so deep, and it helps to get those problems out.

Jeff: At the height of your PTSD and substance abuse issues, did you ever contemplate suicide? You mentioned having 210 rounds in Kosovo, what did you mean by that?

James: You stare at the ammo long enough, you know. I'm sure everyone has had that thought that it would only take one. I'm sure there isn't a person out there that hasn't thought it. That's why I didn't do it, I think I am too much of a coward to do it, but the idea was there. Like I said, with the ammo, it was there, it was attainable.

Jeff: Did you still think about suicide after you got back. There are some who believe that our exposure to what we see, others who have committed suicide, that it lessens the mystique around it and makes us more susceptible?

James: That has always been an issue with me. No one outside of the fire service understands or knows what we see. Nobody should have to ever see what we see. As far as a 2-month old being thrown against a wall because he was crying. At 2's, I think you were there, the little girl that died in the private ambulance in Deeds Park. Nobody should see that. Everyone says, you know what you signed up for, and everyone thinks we have this damned S on our chest like we are invincible, nothing matters, because we push so much inside, we may not have outlets, that unfortunately happens.

Jeff: Have you seen co-workers who you thought might be suffering from the same things you were?

James: Not so much PTSD, because no one talks about it. I am not going to come up to you and say, I've been feeling really bad lately, and I'd like to talk about it, we just don't do that.

Jeff: Do you think there is value in openly talking about it?

James: Absolutely, it gets it off your chest, which is so much better to get it off of you.

Jeff: We are finding how helpful that is…

James: It really is, I found 40 other people who felt just like me. There were members from FDNY, L.A.; We are all the same. No matter what, no matter if you do heroin, meth, or whatever to numb the pain, we are all suffering from the same issues.

Jeff: Do you think going to the treatment center helped you? Did it save your life?

James: Absolutely. I was on the path to nowhere. I mean, my addiction, which stemmed from an on-duty injury, had gotten out of control. I thought I was invincible. My job had started coming into play because of the addiction. It absolutely saved my career and my life.

Jeff: Have the members that know about your treatment been supportive?

James: A lot of them are supportive. You are always going to have a few. I've been called a junkie, and unfortunately, some of the same people that would have their hands out when I would get a big prescription are some of the same people that have said, " you are a fucking junkie," and I am like, are you kidding? I used to supply you. So there is always some. Most of the people have been understanding. We are becoming more open, no one wakes up and says, today, I want to become an addict. It doesn't work that way. There isn't a single addict that has said that.

Jeff: Was the addiction to keep those things at bay?

James: To keep me numb so that I didn't feel a damned thing. I didn't want to talk at all. That's how I dealt with it.

Jeff: When you were in the military, which also has a lot of behavioral health issues, what did they do?

James: Unfortunately, we never talked about it. I mean, the suicide rate wasn't as high as it is now in the military but it goes back to you are a pussy if you go get help. It wasn't posted. I wouldn't know where to get help back then.

Jeff: As an organization, what would you like to see us do to provide more help to those who may be struggling?

James: I think we are reactive instead of proactive. I think we are only doing this now because of the tornados, the mass shooting, and Poole. I don't recall anything the past 12 years. Maybe, some CISD after a fatal fire.

Jeff: Do you think that CISDs are effective?

James: Honestly, I think 90 percent of the people just want to get the hell out of there. Unfortunately, it goes back to the denial. I am a fireman, fuck this, I don't need this when they know deep down inside.

Jeff: What role do you feel our run volume and the truncated sleep patterns have?

James: An absurd amount. Me, for example, you are on the medic, you are up all night, and you come home and sleep. You wake up and it's the worst feeling in the world so you drink to feel better. Then you argue. That's what I found. People are getting burned out. Riding the medic is viewed as a punishment.

Jeff: Is there anything else you would like to add. What would be the warning signs you would look out for in others who may be struggling?

James: I can't comment on the PTSD as much because my problems have been outweighed by my substance abuse issues. Short tempers, argumentative, laziness comes into it. It could be leaving work to fix your problem, borrowing money. One day in a great mood, the next you are not. Nobody saw that with me. I didn't see it. When my addiction came out, it amazed me how many people came out and said. I knew there was something going on.

Jeff: Are you irritated about that?

James: At first, I know at least three times I tried to come out but didn't, I was scared to make it an issue with the job. You don't want to lose your job. We are supermen. I can beat this. It's just a pain problem. Give me a week and I'll be good. It doesn't work that way.

Jeff: How do you see yourself five years from now?

James: I'd like to get my story out there. I am far from fixed even though it's been six months. I could fall back into addiction tomorrow. Anything can happen. In 5 years, I'd like to talk to recruit classes. I know I am not the only member suffering from addiction. I know we have lost members to substance abuse because of work issues. I would like to let people know that they are not alone.

Jeff: What motivates you to keep fighting the fight?

James: I've been told how much of a better person I am all around. I still go to meetings; it's still hard. There isn't a day that doesn't go by that I don't think about taking a Percocet. Just let me get to 1 pm. I am clean today; I don't know what tomorrow looks like. It is extremely hard. Especially coming home from work, being up all night. It was my numbing agent for so long. I don't drink. I don't do anything

now. I really need to find a new outlet. I even gave up golfing because it hurts my injury too much.

James: My addiction caused me two promotions. Studying was put on the backburner because of the Percocet's.

Jeff: One last question, if a fellow employee came up to you and stated that he/she needed help. What would you tell them?

James: I would share my story. You are not alone. It's very comforting to know that you are not alone.

Appendix E

DAYTON FIRE DEPARTMENT

BULLETIN NO.: 71

September 17, 2019

SUBJECT: Healthy Heroes Program

The Dayton Fire Department is excited to roll out a new program to help our personnel become healthier and reduce the musculoskeletal injuries that commonly occur in fire and EMS. As tactical athletes, we have a unique physical demand and skill set needed to perform the rigorous role of first responders. Healthy Heroes is a program provided to the Dayton Fire Department by Premier Health Network that helps address those physical needs. The Healthy Heroes Program is a comprehensive wellness and fitness program designed to increase the effectiveness, efficiency, and durability of first responders. Healthy Heroes prepares the first responder for the physical readiness of the job and also helps fight risk factors associated with sudden cardiac arrest.

Healthy Heroes provides Certified Athletic Trainers, occupational therapy, and education to improve the physical ability and overall quality of life for our personnel. The intent of this program is to help identify physical issues before they become injuries and to help correct them to improve flexibility and mobility. This program is completely voluntary and is bound by HIPAA laws and regulations. What this means to you is that the program is completely confidential and personalized to the individual.

This program will be rolled out in three phases. The first phase will be an introduction about the program presented by Healthy Heroes personnel at district staff meetings on September 24th, 25th, and 26th. Eastside staff meetings will be held at 1300 hrs. And Westside staff meetings will be held at 1400 hrs. Each day.

Following the introduction sessions, the second phase will begin with an individual assessment conducted by the Certified Athletic Trainers. The assessment is used to provide the individual and athletic trainers with a baseline to use as a comparison throughout the program. This assessment lasts about 20 minutes and consists of the following six stations:

 Blood pressure and pulse.

 Height/weight and naval circumference.

- Jump mat/sit and reach.
- Mobility (shoulder, squat, balance).
- Step test for three minutes and heart rate for one minute.
- Push-ups/sit-ups (as many as can be completed in one minute).

The assessments will be conducted at the DFD Training Center on the following Fridays from 0900 – 1300:

- September 27th,2019
- October 4th, 2019
- October 11th, 2019
- October 18th2019

The final phase will be follow-up sessions and injury clinics with the athletic trainers. The Healthy Heroes Certified Athletic Trainers will attend weekly sessions to provide continued training and guidance to our personnel. These sessions will be personalized to the individual participating in the program. The weekly injury evaluation clinics will identify and treat musculoskeletal injuries common to the tactical athlete and strive to prevent minor injuries from becoming major disabilities.

Additional information about the Healthy Heroes Program is available on the Premier Health website:

www.premierhealth.com/HealthyHeroes

Please direct any questions about this program to Lieutenant Sylwestrak (x4530) or Captain Rice (x3142) at the Training Center.

TMR/mw

FILE DATE: October 19, 2019