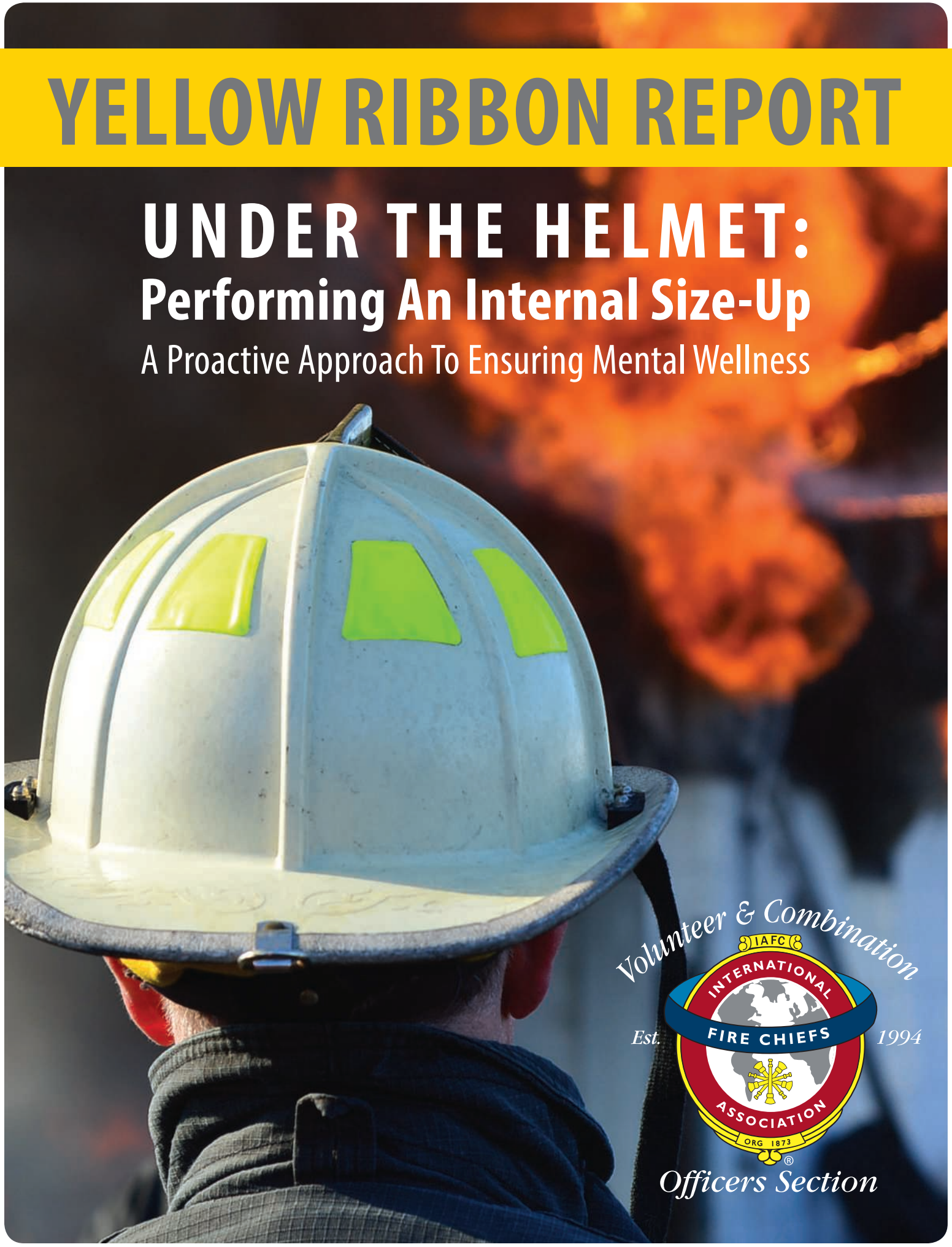
YELLOW RIBBON REPORT

UNDER THE HELMET:
Performing An Internal Size-Up
A Proactive Approach To Ensuring Mental Wellness



Volunteer & Combination

IAFC INTERNATIONAL FIRE CHIEFS ASSOCIATION ORG 1873

Est. 1994

Officers Section

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Performing An Internal Size-Up
A Proactive Approach To Ensuring Mental Wellness

Volunteer & Combination Officers Section

Release Date: July 2017

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Volunteer & Combination Officers Section

VCOS MISSION

To provide chiefs and chief officers who manage volunteers within a volunteer or combination fire, rescue or EMS delivery system with information, education, services and representation to enhance their professionalism.

VCOS VISION

To represent the interests of all volunteer and combination fire/rescue/EMS agencies. We will be a dynamic organization, characterized by our integrity, customer focus and membership development, with value placed on people and the superior utilization of technology. We will excel by creating educational programs, through unrivaled networking, and by helping VCOS members further their success and reach their potential.

Volunteer & Combination
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ORG 1873
Officers Section

Volunteer & Combination Officers Section
of The International Association of Fire Chiefs
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July 2017

Members of the Fire and Emergency Service,

The IAFC's Volunteer and Combination Officers Section always strives to provide resources and information on the most important issues and challenges to volunteer and combination departments and the fire service as a whole. As many of you have seen in news headlines and by talking to your fellow firefighters, we need to improve our focus on responders' emotional health as an industry. We spend so much time helping and saving others, but often forget to focus on one another. As you know, first responders not only have all the "normal" life stressors, but also additional stressors from our public safety role.

The goal of this report is to bring awareness about the fire and emergency services' emotional and behavioral health problem, and emphasize the importance of changing the culture. This report has background information, statistics, resources, and action items for departments to use to ensure the mental wellness of their members. At the very least, I hope this sparks some conversations in your department. We need to start talking about this. It is our duty to take care of each other and our teams.

I want to thank the committee that created this report. The talent, dedication, and passion of the committee members was evident from start to finish. I want to acknowledge Skip Straus, Robin Grant-Hall and Liz Fletcher. The guidance and education they provided to our committee, along with their compassion to assist first responders to understand the value of ensuring mental wellness are priceless. I want to thank John Buckman and Mike Macdonald for tackling the writing and providing direction on this project. To the remaining committee members Jeff Dill, Scott Geiselhart, Tim Pelton, Steve Heitman, Pat Kenny, Scott Kerwood, Jim Wamsley, and Fred Windisch, your contributions and personal experiences added value to assist others to understand the reality of the stresses first responders experience which was the driving force behind this report. I cannot thank you all enough for opening the eyes of many. VCOS thanks the IAFC's Safety, Health and Survival Section for their expertise and partnership on this report as well.

Please put the information in this report to use. Do not just throw it on a bookshelf. Talk about emotional health just like you talk about operational training and readiness. As stated in the report, "It is time we acknowledge and truly understand the ongoing emotional impact on our health and well-being, our lives depend on it."

Respectfully,

Chief Charles Flynn
VCOS Vice Chairman and Yellow Ribbon Report Project Leader

International Association of Fire Chiefs

Providing leadership for the fire and emergency services since 1873

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July 2017

Members of the Fire and Emergency Service,

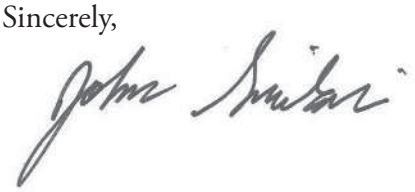
Now more than ever, it is important that we prioritize taking care of our own members in our departments and ensuring their mental wellness and emotional health. This is a top priority in the fire service and has gained much national attention recently. Too often we hear about first responders suffering from cumulative stress overload that leads to depression, anxiety, substance abuse, addictions, and suicide.

Much like we have a duty to serve our communities, we have a duty to serve one another. We must look out for each other unremittingly, not just on the fireground or at the station. It is imperative that we are able to identify the signs of stress and the behaviors resulting from cumulative stress overload.

I commend the VCOS and the other fire service and research partners that came together to develop this report. Clearly, a great deal of hard and thoughtful work went into this report. Please take the time to read it thoroughly and create your own action plan to implement the ideas shared within. Involve all levels of your organization to get buy-in and show that it is a group effort.

As the report states, "We have a saying in the fire service – risk a lot to save a lot. Isn't it time we do the same for ourselves?" Please keep this in mind and take the extra time to check on members after tough calls. Go the extra mile to really listen to them. It could save their life.

Sincerely,



Fire Chief John Sinclair
IAFC President and Chairman of the Board

The issue of behavioral health has affected firefighters for many years without much notice. Acknowledging and accepting the mental and physical impact has only recently been recognized as having a short and long-term consequence on the mental wellness of our brothers and sisters, which we in the public safety community are now beginning to admit. It is a duty of ourselves to accept we cannot always deal with the stress that life and public safety brings to bear upon. The impact stress brings to our family, children, friends and colleagues can no longer be ignored. The use of drugs, alcohol and other stimulants to disguise the symptoms must be recognized and action taken. Mental wellness is a necessary attribute for all public safety response personnel. This report provides information for members of the response community on the signs, symptoms and actions necessary to protect ourselves from the stressors.

John M. Buckman, III

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FORWARD

Today, we as a profession need to protect our greatest asset, the men and women who serve their communities as firefighters and first responders. During a presentation at Symposium in the West 2016, Scott Geiselhart and Steve Heitman (both fire service veterans and contributors to this report) presented on the growing number of suicides in fire and emergency service organizations. Scott went into detail of his experiences as a member of his hometown fire department and shared the details of his battle with PTSD and his own suicide attempts. There were approximately 140 attendees during the presentation and for ninety minutes not one person left the room. Many of the veteran and experienced firefighters, fire chiefs and guests dabbed or wiped away a tear as Scott's experience made the statistics real. The IAFC's Volunteer and Combination Officers Section Board of Directors established a panel to explore developing a Yellow Ribbon Report pertaining to the mental wellness of our members and their organizations.

The goal of this report is to bring awareness about the fire and emergency services' emotional and behavioral health problem, and emphasize the importance of changing the culture. The fire service can easily trace its roots back to a batch of rough and tumble folks who—due to lack of tools, research, and education—often relied on courage and brawn to get the job done. As tools improved and we grew collectively smarter, the behaviors we identified as most risky at the time were addressed and eliminated from the industry as they could be. However, many responders still cling to outdated techniques and procedures as either a way of honoring tradition or hazing the new generation with a ritualistic rite of passage. Not long ago, veteran firefighters derided comrades for wanting to put on air packs before walking into a burning structure. Even today, rookies might express their feelings after their first horrific scene, only to be told by the "seasoned veteran" to "Suck it up, Buttercup." Let us be clear, the "Suck it up, Buttercup," mentality is NOT the approach to take.

This report has background information, statistics, resources, and action items for departments to use to ensure the mental wellness of their members. It is our duty to take care of each other and our teams and to remember those who we have lost to behavioral health suicides—it is in their memory that this report is dedicated.

CHAPTER 1: INTRODUCTION

We often hear the public say of us:

> **"They are a different breed—it takes a special type of person to run toward danger while everyone else is running away."**

This statement captures the essence of what first responders do. Whether it be bravery, courage, selflessness, valor, or heroism (with a little excitement and curiosity thrown in), first responders are somehow instinctively "programmed" in their DNA to help and protect others. First responders seem to have a brain that is uniquely wired to respond to crises with an uncanny focus to get the job done, yet the necessary resilience to cope with the resultant exposure to highly stressful situations. First responders are exposed to scenes and situations that are beyond the comprehension and coping capabilities of the average person; they see, hear, and smell what no human being should ever have to experience. It is no wonder that constant exposure to such events can result in cumulative stress that can potentially impact the individual's emotional well-being. The reactions to these stressors and the resulting emotional toll can create behavioral health issues, many times beyond the understanding of the person affected. The manner in which the first responder copes with this cumulative stress can impact one's career, family, enjoyment of life, and overall well-being.

What's in a name? We love labels, particularly the alphabet soup of acronyms that we in fire/EMS use to remember things. In looking under the helmet and conducting an internal size-up, we had to consider what terminology to use—is it emotional, mental, psychological, or behavioral health? The term "emotional health" is used herein since it appears to be the most personalized and least threatening. For example, from a firefighter's point of view, we can imagine the following dialog:

> **"If you say I have a mental health problem that means something is wrong with me and that I'm crazy. The same goes for psychological health, except that probably means more labeling. If you say I have a behavioral health problem then it must be my fault. However, when you say I have an emotional health problem, I can buy that; it sounds less threatening and less permanent, as in I can deal with it if I get help, unlike permanent mental illness."**

For the purposes of this report, we use the term "emotional health" to refer to the impact of cumulative stress overload on the individual. We use the term "behavioral health" to refer to potential downstream behaviors resulting from cumulative stress overload such as anger, avoidance, substance abuse, addictions, and other adverse outcomes, including suicide.

First responders are subject to the same stressors as everyone else—careers, relationships, spouses, children, finances, as well as the everyday hassles of being alive in this world (i.e., traffic, waiting, other people's behaviors). However, in addition to these "normal" stressors, we must deal with the

additional stressors that our role in public safety creates. Every time we go on a call, we have the potential of facing moments that range from dumpster fires and minor traffic incidents to major structural fires and fatalities to unthinkable mass-casualty events. We never really know exactly what we are facing until we are on scene. Additionally, due to the nature of emergency response and the rest of the world's definition of "emergency," we also are called to a seemingly endless stream of non-emergency events, false alarms, public assistance calls, and even repeat-visit medical calls to the same address.

Every first responder on the job has had overwhelming experiences that create a stress-related reaction. It is the responder's reactions to this cumulative stress that can impact the individual's long-term emotional health and well-being.

The variability as well as the frequency of these calls contributes to our stress response, and how we handle this stress is one of the most important contributors to our emotional health and resilience. For imagery, think of pouring water continuously into a bucket; unless the bucket gets dumped out occasionally, it will overflow. Likewise, if our stressors and emotional responses don't get processed, they can cause an overflow in our brains, which is commonly referred to as Post Traumatic Stress Disorder (PTSD). Note that we are not using the PTSD label in this report. There are two reasons for this. First, "Post Traumatic" typically implies that there is a particular trauma in the past that is causing our reactions; this is not necessarily the case in first response since it can be repeated exposures causing this state, rather than one specific event. Second, regarding "Disorder," there is nothing "Disordered" about a first responder's natural reaction to repeated exposure to stressful events. As such, we propose a new term, "Cumulative Stress Overload," which we think is more descriptive and accurate. Cumulative Stress Overload is what happens when first responders, who start with the same everyday stressors as the rest of the world, add to their day an additional layer of extreme stress experienced in the line of duty (there are exceptions, of course: mass shootings, bombings, terrorist attacks, etc).

The fact that these stressors exist is not the problem or issue at hand. There are numerous scientific studies which have identified the brain's physiological response to stimuli in terms of neurotransmitters (e.g., cortisol, epinephrine), as well as other studies on the physiology of the stress response, and current best practices in treatment. **(For a sampling of these studies: http://www.apa.org/topics/stress/index.aspx)** However, these studies are beyond the scope of this report. Rather, the purpose of this report is to shed light on Cumulative Stress Overload and bring awareness to its harmful effects on first responders' emotional health and well-being. In addition to increasing awareness of emotional health, we want to emphasize what can occur when this issue is ignored—potential adverse downstream events such as depression, anxiety, substance abuse, addictions, and ultimately suicide. Furthermore, we want to emphasize the importance of emotional and behavioral health education, suicide prevention programs, reaching out to those needing help *before* they are in a crisis, and changing the culture in the fire service to reduce the stigma and embrace the problem. It is time to acknowledge and truly understand the ongoing emotional impact on our health and well-being; our lives depend on it.

CHAPTER 2: REASON AND UNDERSTANDING

There can be no argument that it is the obligation of every member of the emergency response organization—spearheaded by its leadership—to accept accountability for the safety and well-being of his/her brothers and sisters. This attitude is well ingrained when it comes to physical safety on the fireground; however, it is much less ingrained when it comes to the emotional well-being of our personnel. The overall health (physical and emotional) of each firefighter or medic can determine the health of the entire organization in terms of morale, public perception, recruiting, and retention.

> **"I asked for help. I begged my brother and sister for help. They ignored my plea. They weren't behaving with malicious intent. They did not know the action to take to help me."**

PROBLEM STATEMENT

There is a long-standing avoidance of acknowledging and addressing emotional health within the emergency response community. Whether that problem is currently growing, or whether it has always been there, is debatable. Perhaps, we are now more aware of it or finally being more honest about it. The bottom line is that we, as an industry, do not have a good track record in ensuring emotional health. Instead, we have ignored how such issues impact a person's ability to successfully function on the job with the community and co-workers, and at home with family and friends. Most of all, we have ignored the impact that cumulative stress overload has on our bodies, especially as we age.

It has traditionally been perceived as a sign of weakness to ask for help in dealing with an overwhelming reaction to an incident. Sometimes, responders wait for years to seek help, and then only seek help because they are pushed by a co-worker, friend, or family member. There is a fear of being ostracized by telling our brothers and sisters that we are having a hard time dealing with a call; there is also a fear that if the command staff finds out that we are struggling, that we will be viewed as unfit for service.

ACTION STATEMENT 1:
During recruit school, emotional and behavioral health, as well as dealing with cumulative stress, must become integrated into the initial education.

The dirty secret of our profession is that we are suffering silently, and in many cases the signs and symptoms of emotional health challenges are being ignored. This has to change—we need to wake up and address this issue. Additionally, because first responders are supposed to be tough and able to take it, any sign of perceived weakness can be interpreted as non-compliant. The public safety community, including fire service leadership and elected officials, must recognize the need to address the soft issues as well as technical competencies in personnel development. This will require a significant cultural shift in attitude and action.

BATTLING THE STIGMA

As those who wear glasses can attest, before they got that first set, they assumed their sight was exactly what everyone else saw. However, in that first visit to the optometrist, they suddenly realized things were amiss; after the new glasses went on, they finally saw how things are supposed to look. The brain is similar. We may not know how or why we know something, but we spend our entire life relying on our brain without question. Unfortunately, we don't know how our brain should be functioning, and so we have no basis for comparison. As we discuss in this report, people who are attracted to the emergency response sector and who are good at it, typically have a gift for processing situations and information in a certain way that most others can't—not unlike how an accountant can work math problems in his or her head or a musician can grab a guitar and play a song by ear.

Many seasoned first responders have the ability to handle stressful situations, deal with the unknown, calm excited people, and withstand gruesome scenes while performing heroic acts to save lives, and continue to make rational decisions while others around them are losing their heads. The ability to deal with all these on-the-job stressors, plus all the other parts of daily life everyone else faces, is almost an afterthought because as first responders, that's what we do.

"Roughly 50% of the U.S. population is exposed to traumatic stress, but only 5%-10% develop PTSD" (Ozer et al., 2003, p. 54). Assuming this statistic is accurate, then it might be reasonable to say that 100% of emergency responders are exposed to traumatic stress.

At least that's what we do until the day our internal stress "bucket" becomes full.

The fact is, first responders are human, and although we are wired to deal with difficult situations better than most, we can reach a breaking point. Today, with the emphasis on military veterans returning from deployment, most everyone is familiar with the term "Post Traumatic Stress (PTS)". As discussed

Needs of response personnel in dealing with and/or discussing behavioral wellness issues:

- Trust established
- Confidentiality ensured
- Guaranteed no loss of job or status
- Feel safe and secure
- Able to tell their story without prejudicial judgement
- Able to tell their story without fear of retribution
- Connect with others
- Develop coping skills and resilience

in the previous chapter, we now know that it doesn't necessarily take experiencing combat in a war zone to suffer from PTS symptoms. As first responders, we encounter situations on a daily basis that have the potential to impact us emotionally. This cumulative stress overload can create troublesome thoughts of a particular incident which may be emotionally upsetting and distracting. Since we hate feeling out of control or helpless, we may stuff the feelings down and pretend that everything is OK. Unfortunately, it's part of our tradition—our armor—to discount these feelings; we act as if these calls don't affect us.

SUCK IT UP, BUTTERCUP

There has been little written and minimal education provided to our officers (and to our cadets, our firefighters, and our chief officers) on how to process traumatic calls, and what to do if we are having difficulty dealing with some of these events. Left unprocessed and stuffed down, these emotions can manifest themselves in other ways, leading to anxiety, depression, substance abuse, and addiction. The most severe symptom of our industry's culture related to the chronic cumulative stress overload is the high incidence of suicide as compared to the general population. After years of protecting our fellow man and saving a multitude of lives, this is a tragic ending to such an admirable career. We predict that this statistic will drop significantly if responders protect themselves, take care of each other, and seek treatment to combat the effects of this exciting and gratifying, but stressful vocation. We responders need to be responsible for our emotional health and well-being and that of our brothers and sisters. Our officers need to be committed to the same, as well as reducing the stigma and changing the culture to create a climate where these issues are acknowledged and seeking help is not only encouraged, but expected. When a fellow responder has committed suicide, we have failed.

In many ways, people in the general population do not know how to respond to emotional and behavioral health issues such as depression, anxiety, substance abuse, and addictions. Furthermore, there is a general unfamiliarity with how to address matters surrounding suicide; as such, people tend to overlook (both intentionally and unintentionally) signs and symptoms, and can potentially do more harm than good.

ACTION STATEMENT 2:
Fire departments need to become familiar with emotional and behavioral health issues and methods of reducing their impact on members.

Most fire departments do not have the knowledge and resources to deal with the complex issues surrounding behavioral health and suicide. Often, confronted with the possibility that someone may be suicidal, the opportunity for prevention may be lost, or worse, their suicidal thoughts may be exacerbated by words that may be perceived as condemning. Overcoming the darkness felt by those individuals is a serious challenge to survivability.

When a responder commits suicide, there is frequently little warning or awareness by co-workers that the person's life was in danger. Once we enter the world of darkness fueled by years of traumatic calls and "living" with death, it is difficult to reach out for help. The firefighter's greatest fear is his/her peers and the command staff looking down on him/her and saying things that worsen the person's state of mind, rather than help. As a group, responders rarely reach out for help; the fear of being deemed

unfit and jeopardizing the job and pension and the risk of being judged or scorned often tragically fuels the choice to choose suicide over asking for help.

The fire service can easily trace its roots back to a batch of rough and tumble (mostly) men who—due to lack of tools, research, and education—often relied on courage and brawn to get the job done. As tools improved and we grew collectively smarter, the behaviors we identified as most risky at the time were addressed and eliminated from the industry as they could be. However, many responders still cling to outdated techniques and procedures as either a way of honoring tradition or hazing the new generation with a ritualistic rite of passage. Not long ago, veteran firefighters derided comrades for wanting to put on air packs before walking into a burning structure. Even today, rookies might express their feelings after their first horrific scene, only to be told by the "seasoned veteran" to "Suck it up, Buttercup." **Let's be clear, the "Suck it up, Buttercup," mentality is NOT the approach to take.**

Emotional and behavioral health issues are nothing new to our industry. Unfortunately, we've never been particularly good at addressing them, often leaving our members who needed help the most feeling excluded, isolated, and ashamed. The "suck it up" mentality left those suffering to self-medicate, often turning to self-destructive behaviors such as substance abuse, extramarital affairs, various other addictions, and in the worst cases, even suicide.

The way we view mental wellness as a society has been (slowly) changing, but still our emergency response organizations are hesitant to follow suit. In addition to the tradition of physical and mental toughness, there is a trust issue that is necessary—to believe the person next to you is competent and will protect you at all costs. That is certainly an important belief as people battle life-threatening situations together as a team, but it is not realistic if it does not account for human reactions and emotional limits. In today's environment of reduced staffing for career-staffed departments and declining ranks in volunteer departments, the firefighter is asked to do more with less. A successful team must be able to rely on each member to perform flawlessly under the most trying of circumstances; responders are expected to go from 0 to 60 mph in seconds to react quickly to a situation, and then perform heroically to save lives and protect property during an event they may not have encountered very often.

ACTION STATEMENT 3:

Education programs need to be developed for company officers, as well as cadets and chief officers. Access to this behavioral health education must become part of the professional development process.

Over the years, the fire service has talked about the need for cultural change regarding various issues in the fire service/emergency response sector. The National Fallen Firefighter Foundation has identified the need for cultural change as one of the most important priorities to changing the way the fire service perceives risk and gain. The way we talk about and deal with emotional health issues now leads that list. **As a chief or chief officer, it is incumbent on you to accept personal responsibility for facilitating and maintaining the emotional and physical health of your responders. We need you to recognize and accept emotional wellness as a legitimate obligation for every responder and department—yes, even yours.**

CHAPTER 3: SIZING IT UP

Mental, Emotional, and Behavioral Health have become significant issues in this country in all populations—not just emergency services. For example, according to the National Institutes of Health (NIH), in 2015, approximately 17.9% of adults in the U.S. experienced mental illness (NIH, 2015a), with 4% experiencing a serious mental illness that interfered substantially with or limited one or more major life activities (NIH, 2015b). Regarding depression and anxiety specifically, in 2015, 6.7% of adults in the U.S. experienced at least one major depressive episode (NIH, 2015c); 18.1% experienced an anxiety disorder such as post traumatic stress disorder, obsessive-compulsive disorder, and specific phobias (NIH, 2015d).

Regarding PTSD in particular, Kessler et al. (2005a) found that 3.5% of the U.S. adult population experienced PTSD symptoms within the past year; the lifetime prevalence is estimated at 6.8%. The National Center for PTSD (2016) reports the lifetime prevalence to be 7-8%.

PTSD rates in emergency services have been found to be significantly higher than that of the general public. For example, in a literature review of PTSD in rescue workers, Berger et al. (2012) found a worldwide prevalence of 10%; the rate in the general population from diverse countries varied from 1.3% to 3.5%. Specific to firefighters, several studies have found rates in the range of 20-22% (Beaton and Murphy, 1993; Corneil et al., 1999).

Suicide is the 10th leading cause of death in the U.S., representing 1.6% of all deaths in 2013, according to the American Association of Suicidology (U.S.A. Suicide, 2015). It is the 2nd leading cause of death for people aged 15–34 and the 4th for those aged 35-44, according to the Centers for Disease Control (CDC, 2013). The U.S. Department of Health and Human Services (HHS) states that among adults aged 18 years or older in the U.S., during 2013, 3.9% of the adult U.S. population reported having suicidal thoughts in the past year, 1.1% made a suicide plan, and 0.6% attempted suicide (HHS, 2014). Over a lifetime, rates of suicidal ideation were reported to be 13.5%, rates of suicide planning 3.9%, and rates of suicide attempts 4.6% (Kessler et al., 1999).

In the fire service, these rates are even higher. In a recent study of 1,027 current and retired firefighters, rates of ideation, planning, and attempts were 46.8%, 19.2%, and 15.5%, respectively (Stanley et al., 2015). In a review of the literature on suicide in fire, EMS, and law enforcement, Stanley, Hom, and Joiner (2016) state that while there is a large body of research on suicide in police and emerging research in firefighters, there is a paucity of literature in EMS. However, in the 2015 study mentioned above, the authors found that the firefighters who were in departments that responded to EMS calls were six times more likely to have made a suicide attempt during their careers than those in non-EMS departments.

STRESS: THE GOOD, THE BAD, AND THE UGLY

When we talk about stress, we are almost always talking about life's stressors. However, it is our response to these perceived stressors that causes the release of neurotransmitters (chemicals and hormones) in our body; for example, adrenalin and cortisol ramp us up in response to a perceived stressor. **(For a more in-depth look: http://www.health.harvard.edu/staying-healthy/understanding-the-stress-response)** Stressors are the stimuli that cause these chemical releases—the things in life that put us on alert, scare us, weigh on us, and/or otherwise make us feel we are under pressure. In short bursts, this is referred to as acute stress; we often find this chemical release exciting and enjoyable, such as when we are watching a scary movie or riding a rollercoaster. Other times it is less enjoyable, such as when we hear a loud noise or are startled by something unexpected. This chemical release gives us our "fight-or-flight" reflex, which can be truly life-saving since it helps us maneuver through dangerous situations. When it is triggered, muscles tense, breathing and pulse quicken, digestion stops while the body is pumped with glucose for energy, and the brain increases its demand for oxygen by pumping the heart. Since most of the neurotransmitters are located in the brain and gastrointestinal tract, when the brain hoards oxygen, it causes non-essential body functions to slow down, and explains why we get that "gut feeling."

Once the stressor (or threat) is removed, body systems return to normal. However, if the stressor remains present—problems at work or with family, money, etc.—the body adapts to the increased chemical presence, which leads to chronic stress. The brain gets tired of the constant ups and downs so it chooses to remain ramped up permanently as an adaptation. This is typical for first responders due to the constant reactions to stressors in the line of duty, and is why hanging out at home with family and trying to relax (without the help of alcohol) is often difficult for us. Chronic stress can lead to problems with the digestive, excretory, respiratory, circulatory, and immune systems. Furthermore, stress also causes insulin to be produced for energy, an excess of which causes salt increase, water retention, and deposits of fatty buildup within the arteries. That's why long-term chronic stress can lead to not only mental "burnout," but also serious physical conditions including weight increase, high cholesterol, hypertension, heart disease, diabetes, heart attacks, strokes, and more. It is well known that increased cortisol levels lead to abdominal weight gain; yes, stress makes us fat.

BEHAVIORAL REACTIONS TO STRESS

Physiological and psychological reactions to stress can occur in the short term (within hours or days of a traumatic event) and long term (months to years after one or more incidents).

Common short-term reactions include:

- Emotional responses
- Disrupted sleep or insomnia
- Confusion or lack of clarity
- Denying or minimizing the event's impact on us

These short-term reactions can lead to long-term reactions such as:

- Worry and anxiety
- Lowered frustration tolerance and impatience
- Irritability
- Depression or feelings of numbness
- Denial or minimization of impact
- Sleep problems, insomnia
- Nightmares, night sweats
- Teeth grinding (bruxism) at night or even while awake

Both short-term and long-term reactions can lead to behavioral health problems such as:

- Use of alcohol and/or drugs to "self-medicate"
- Increased risk taking and reckless behavior
- Increased addictive behaviors (gambling, hyper-sexuality)
- Work performance issues or problems functioning
- Suicide

The body's acute stress response in the short term, as well as chronic responses in the long term, can lead to problems. First responders have a "double-whammy" in that they experience chronic exposure to acute stress, resulting in cumulative stress overload, to which we referred earlier. The stress bucket has become full; it is imperative that it be dumped out.

WHEN WE ARE STRESSED:

- **Blood pressure increases**
- **Breathing becomes more rapid**
- **Heart rate increases**
- **Muscles tighten**
- **The digestive system slows**
- **The immune system decreases**
- **Alertness (tension) heightens**

THIS CAN LEAD TO:

EMOTIONAL/BEHAVIORAL ISSUES. Constant stress hormones leads to tension, anxiety, and sleep problems, which in turn lead to headaches, moodiness, depression, and various detrimental behaviors.

WEIGHT GAIN. Cortisol makes you crave fats and carbs, which are likely to add weight to the abdominal area, raising the risk of diabetes and heart disease.

DIGESTIVE PROBLEMS. The slow release of acid doesn't allow the stomach to empty, leading to stomach aches, while a sped-up colon can lead to diarrhea.

HEART ISSUES. Cortisol increases heart rate, blood pressure, and cholesterol levels, thus increasing the risk of heart attacks and strokes.

IMMUNE SYSTEM PROBLEMS. Chemicals that would otherwise be used fight illness are tied up, thus opening the body to colds and infections. Chronic stress has been shown to actually damage immune cells, which lowers our ability to fight infection, cancer, and other illnesses.

Recognizing and dealing with acute stress overload varies highly among individuals. Some people may recognize a change in mood and seek help by talking to others. Others recognize changes in behavior such as increased alcohol consumption, and take steps to reduce or eliminate the behavior, seeking help if necessary. Others may not notice subtle changes in mood and increased self-medication until they are further down the pathway; perhaps they are engaging in addictive behaviors and reckless driving. Still others may not notice a problem at all, and it takes a specific incident at work or a co-worker confronting them about their behavior to make them wake up. Sometimes an individual is so good at hiding behaviors that others are in a complete state of disbelief when an adverse event occurs. For example, sometimes colleagues are absolutely shocked when a fellow first responder takes his or her own life—not only did they not notice any warning signs of suicide, they didn't even know the person was in trouble and headed down that road.

PHYSICAL SYMPTOMS

*Any of these symptoms may require medical attention.

- Chills
- Thirst
- Fatigue
- Nausea
- Fainting
- Twitches
- Vomiting
- Dizziness
- Weakness
- Chest pain
- Headaches
- Elevated BP
- Rapid heart rate
- Muscle tremors
- Shock symptoms
- Grinding of teeth
- Visual difficulties
- Profuse sweating
- Difficulty breathing

EMOTIONAL SYMPTOMS

- Fear
- Guilt
- Grief
- Panic
- Denial
- Anxiety
- Agitation
- Irritability
- Depression
- Intense anger
- Apprehension
- Emotional shock
- Emotional outbursts
- Feeling overwhelmed
- Loss of emotional control
- Thoughts of suicide/homicide
- Inappropriate emotional responses

COGNITIVE/MENTAL SYMPTOMS

- Confusion
- Nightmares
- Uncertainty
- Hyper-vigilance, watchful
- Suspiciousness
- Intrusive images
- Blaming someone
- Poor problem solving
- Poor abstract thinking
- Difficulty with numbers
- Poor concentration/memory
- Disorientation of time, place or person
- Difficulty identifying objects or person
- Heightened or lowered alertness
- Increased or decreased awareness of surroundings

BEHAVIORAL SYMPTOMS

- Withdrawal
- Antisocial acts
- Inability to rest
- Intensified pacing
- Erratic movements
- Change in social activity
- Change in speech patterns
- Loss or increase of appetite
- Hyper-alert or sensitive to environment
- Increased alcohol consumption
- Change in usual communications

TIPS FOR DEALING WITH STRESS

As mentioned previously, short-term reactions to stressful events can lead to long-term chronic stress, which may ultimately lead to emotional and behavioral health problems. It is critical that we be proactive in learning to manage our stress by focusing on habits and practices which foster resilience.

1. EXERCISE. Even moderate exercise pays huge dividends. Physically, it helps control our weight, and mentally, it elevates our mood. Cardiovascular exercise, in particular, can be a tremendous stress reliever.

2. RESPECT YOUR BODY. Don't smoke, get plenty of sleep, eat smart, and if you drink alcohol, do so in moderation. Do not resort to alcohol and/or drug use as a way to self-medicate to treat stress symptoms rather than seek help. Use caffeine consciously and in moderation. Limit your intake of junk foods that are salty, mostly sugar, and full of trans fats and other harmful chemicals.

3. BREATHE. Research shows just five minutes of mindful, deep breathing can make a significant positive impact on our state of mind. Tie it in with yoga, tai chi, meditation, or a massage for even better results. After a stressful call, consciously breathe deeply in and out of your stomach to help alleviate the stress hormone buildup.

4. TALK IT OUT. Sometimes just saying the words aloud is enough. Slowing down long enough to have a meaningful conversation also helps. If you feel stress building, talk to someone in your family, a friend, coworker, counselor, religious leader, or with whomever you can open up. Responders understandably don't want to traumatize others with what they have experienced. However, you can talk about your feelings and mention that there was something about a call that really got to you without having to share the details. Your loved ones and friends want to be a part of your lives—don't shut them out.

5. GET CONTROL OVER YOUR LIFE. When we feel out of control regarding any aspect of our life, our stress hormones are activated. Think about aspects of your life—your home environment, family life, goals and aspirations, vacation dreams, spiritual or religious life, activities and interests that you've let go of or neglected—and consciously plan and live your life. Living consciously (mindfully) helps us feel in control of our life and future, rather than living in a reactive, powerless manner.

6. PRACTICE MINDFULNESS. Living mindfully means living in the present, the here and now—not in the past or the future. An increased awareness of self and paying attention to what is happening in the moment can help us recognize the signs and symptoms of stress in ourselves; it can also help us recognize those signs and symptoms in others so that we are able to reach out and help.

CHAPTER 4: RECOMMENDED ACTIONS

In the following discussion, we make recommendations for taking action to implement changes to combat the impact of emotional and behavioral health on the individual and the organization, as well as reduce the stigma of emotional and behavioral health and change the culture in the fire service.

ACT LOCALLY

National organizations such as VCOS and the IAFC are committed to working with the national and state fire academies and federal organizations to change standards and move the conversation about emotional and behavioral wellness forward. However, in order for these initiatives to gain traction, department leadership must work locally to change the culture at the department level.

The healing and rebuilding process for the individual is an essential component of behavioral health treatment. A similar healing and rebuilding process can have a significant positive impact on the organization as well. Leadership needs to recognize the negative impact of cumulative stress overload and take steps to ensure the well-being of personnel.

CULTURE OF ACCOUNTABILITY

We all know and accept the OSHA "two-in, two-out" policy that says never go into a dangerous situation alone, and that two others are geared up and ready to go inside the hazard area should trouble arise and those in harm's way need assistance. We have significantly improved our track record with accountability on the fireground. However, we are suggesting a different kind of accountability—accountability in establishing an organizational culture that embraces the emotional safety of the firefighter in addition to physical safety. As such, we are suggesting "two-in, *three*-out" to conceptualize the idea of a third person or entity which has the firefighter's back on an *emotional* level. This third entity could be a specific person whose role is to be available (not necessarily literally on scene) for emotional wellness support should the need arise. This individual could be a department ombudsperson, a chaplain, a behavioral health professional, or a peer support team. We are adamant in our practice of establishing a RIT team on the fireground; we need to be just as adamant about the importance of "emotional RIT."

In order to change the culture at the departmental level, leadership must make a strong, visible commitment to ensuring the emotional well-being of everyone in the organization.

- Work to establish an environment where individuals are comfortable discussing emotional health, particularly the bad calls that haunt them. Demonstrate and encourage open and honest communication. Proactively seek ways to address emotional and behavioral health issues *before* they become significant problems. The stigma of emotional and behavioral struggles being viewed as a sign of weakness must be eliminated.

- Officers and command staff should be trained in learning how to be active listeners and approachable to those wishing to reach out for help. These leaders also need to know what to do when someone asks for help—how to talk to the person, and how to ensure that the individual receives the proper care according to the department's protocols.
- Improve awareness of emotional well-being throughout the department. Offer seminars and workshops on emotional and behavioral health and suicide prevention. Many departments are in the process of developing and implementing wellness and fitness programs—make emotional wellness just as prominent as physical wellness.
- "Walk the Talk." It is of critical importance that the command staff and officers demonstrate their commitment to changing the culture through their own behavior—be a role model. The best plan may be developed, but it will never be successfully implemented without demonstration of commitment from the top. If an officer or chief fails to encourage open communication or facilitate debriefing after a bad call, that behavior will set the tone for the rest of the department. Leadership must "walk the talk" even if it means difficult conversations.

EDUCATION AND TRAINING

In addition to a culture that fosters open communication and trust, the organization must establish an awareness of emotional and behavioral health in order to effectively help those who reach out for help. Those in leadership positions need to have adequate training in order to recognize emotional and behavioral health problems, know how to address them, and know how to get the person help. Furthermore, cultural change can only be affected if an awareness of and a commitment to emotional and behavioral wellness permeates the organization—at all levels.

Learning to take yourself lightly and your problems seriously may improve your quality of life only a little, but small changes can have great consequences.

- Develop and implement education for all ranks that promotes emotional wellness, beginning in the academy and continuing throughout all members' careers (or membership tenure for volunteers), even into retirement. Offer programs on stress management, substance abuse, and suicide prevention. Include family members to the extent possible so that they can encourage their loved ones to make healthy choices and to seek out help when needed.
- Include a behavioral health component in officers' professional development courses and other required training.
- Introduce emotional and behavioral health programs/policies from the beginning of employment (or membership) as part of the overall compensation and benefit package. Treat emotional and behavioral health the same as physical health—insurance companies are now required to do that, why can't we? Inform employees of insurance benefit package coverage, policies, and limitations. Include family members in new employee orientation.

- Recognize and understand the impact of emotional and behavioral wellness issues in terms of your agency's recruiting and retention initiatives. Discuss the importance of emotional and behavioral health when recruiting to ensure candidates' expectations are realistic. Conduct exit interviews with those leaving to help determine if there are significant cultural issues in the organization and seek opportunities for improvement.

SUPPORT MODEL AND INFRASTRUCTURE

Departments will choose different models and infrastructures with which to provide emotional and behavioral health support to personnel. Departmental resources, among other constraints, will dictate the choice of approach and method of implementation. In addition to education and training of officers and command staff, it may be helpful to identify a "champion" (an ombudsperson or coordinator) to help develop and implement these initiatives. Someone (preferably *not* an officer) with respect up and down the chain of command would be an ideal choice. This individual should be trained in emotional/behavioral health and suicide prevention/intervention through seminars, courses, and conferences; this training needs to be ongoing and not just a one-time event. Additionally, forming Critical Incident Stress Management (CISM) teams or other peer-support programs throughout the organization can help to reduce the stigma by including more people in development and implementation.

Develop and implement the support system that is best for your organizational culture and infrastructure.

- **Peer-support Program.** Identify those individuals in the department who are well-suited and have the desire to serve in this capacity; these individuals should be trained using known peer-support models (e.g., ICISF classes).
- **Chaplaincy Program.** Chaplains should have education, training, and experience specific to the fire service. Selecting a chaplain who is or has been a first responder is ideal. Consider sponsoring one of your own who has felt the call to go through training to become a chaplain.
- **Employee Assistance Program (EAP).** Ensure that EAP personnel are vetted and have specific education in firefighter culture, exposure to trauma, and the unique experiences that we encounter that can lead to emotional and behavioral health problems.
- **Other Behavioral Health Resources.** Even if your department has an Employee Assistance Program (EAP), it may be beneficial to identify therapists who specialize in working with first responders as an additional resource.
- **Treatment Programs.** Become aware of outpatient and inpatient professional treatment programs which are appropriate for first responders.
- **Other Organizations.** Use the resources from the IAFF Behavioral Health Program, NFFF, Firefighter Behavioral Health Alliance, IAFC, NFPA, NVFC, and others. Additional resources are mentioned at the end of this report.

IMPLEMENTATION

Implementation methodology can determine the success or failure of initiatives; this is especially true for initiatives that depend on a dramatic change in organizational culture in order to be successful. We suggest a "sandwich approach" to implementation, which is a combination of top-down and bottom-up strategies. Specifically, initiatives should be implemented from the top down so that leadership can demonstrate commitment to the importance of the issue, as well as allocate resources for program development and implementation. At the same time, these initiatives also need to be led at the grassroots or bottom-up level so that every member of the organization is involved and has buy-in. Top-down initiatives without simultaneous bottom-up involvement have a long history of failure in corporate America. While we are cognizant of the chain of command in the fire service (top-down), we also recognize the importance of buy-in at every level in the organization. We envision a scenario in which the chief and command staff demonstrate commitment to a behavioral health program, with that program reaching down to the station and company levels. Furthermore, this program should also reach down to the cadets in the academy. There is a parallel to efforts made to improve safety on the fireground—while there is a designated safety officer in place, it is also *everyone's* job to maintain situational awareness and notify command of any potential hazards or unsafe practices.

ACT NATIONALLY

Help us:

- Work toward reducing the stigma of emotional and behavioral health by changing the culture in the fire service.
- Create and contribute to a centralized data collection point for mental health and suicide data. The Firefighter Behavioral Health Alliance (FBHA) is the organization that is currently collecting and tracking these data.
- Recommend that fire chiefs report suicides to FBHA.
- Mandate *anonymous* reporting of critical incidents as well as success stories (like the Firefighter Near Miss Reporting System).
- Develop action plans that are not seen as punitive; firefighters will be much less likely to ask for help if they think their jobs are on the line.
- Define the threshold of behavior that triggers an action requiring counseling.

ORGANIZATIONAL INTERNAL SIZE-UP QUESTIONS

- **How do we get supervisors to stop sticking their heads in the sand?** The responsibility of leadership is to care about the *whole* individual and this includes emotional wellness. Caring requires actions when our brother/sisters are showing signs of cumulative stress overload. This is all about seeking out education and training—not about indifference.
- **How do we get chiefs to accept a paradigm shift in how work performance issues due to cumulative stress overload are addressed and handled?** The manner in which a supervisor discusses this with an employee can have a huge impact on that employee's well-being. Positive approaches utilizing "coaching methods" and performance plans, rather than negative approaches with punishment, need to be included in management training of officers. How do we convince funding sources to budget money for *mental* wellness education and ongoing in-service programs?
- **How do we address the traumatic stress reactions in responders' daily lives?** How do we emphasize that these stress reactions are completely normal and that it is a good thing to talk about these reactions and seek help when needed and not wait until a crisis occurs? Below are some helpful links on stress management.
- **The Mindful Self Express – The Mind-Body Experiment**
  https://www.psychologytoday.com/blog/the-mindful-self-express/201410/find-relief-the-stress-lifes-daily-hassles
- **Stress Management – Using Self-Help Techniques for Dealing with Stress**
  https://www.helpguide.org/articles/stress/stress-management.htm
- **NIH – 5 Things You Should Know About Stress**
  https://www.nimh.nih.gov/health/publications/stress/index.shtml
- **NIOSH-CDC – Stress at Work**
  https://www.cdc.gov/niosh/topics/stress/

THE CHECKLIST

BE PROACTIVE and accept accountability for the emotional well-being of your organization.

- ☐ Address rumors, innuendo, hazing, and harassment issues immediately.
- ☐ Consider debriefings which include a check-in about thoughts, feelings, and emotional reactions after calls.
- ☐ See something, say something. "All firefighters must be empowered to stop unsafe practices" (NFFF 4th Life Safety Initiative).
- ☐ Create a line item within the organization's budget for mental and physical health.
- ☐ Acknowledge that substance abuse could be a problem within your organization and develop a monitoring process.
  - ☐ Add random drug testing.
- ☐ Develop a mental health assessment tool for determining the need for emotional and behavioral intervention.
- ☐ Acknowledge and develop a process that mental health "injuries" should be addressed in a similar manner as a broken arm; once declared fit for duty, it is no longer an issue.
- ☐ Work within the existing organization's culture to eliminate the "suck it up" attitude and remove the stigma surrounding mental illness.
- ☐ Hold debriefings after events (a mental health hot wash similar to an operational hot wash - may be combined to overcome resistance).
- ☐ Provide education on how to conduct and evaluate personnel debriefings.
  - ☐ Learn the technique of leading conversations/proper questioning relating to discussions about stress.
  - ☐ Enhance active listening skills.
  - ☐ Develop a technique similar to structured time out (out of service).

PSYCHOLOGICAL FIRST AID

Contact and Engagement – acknowledge their feelings are legitimate

Safety and Comfort – reassure that you want to help

Stabilization – assure them there is help available and you will help them receive that help

Information Gathering: Current Needs and Concerns – asking the right question in the correct manner that elicits an answer other than yes/no or good/OK

Practical Assistance – the reality of assistance and the effort required to get out of the situation we are currently in

- ☐ Observe and track behaviors on the job.
- ☐ Listen and recognize problems during discussions about behaviors off the job.
- ☐ Develop relevant SOPs/SOGs.
- ☐ Establish the ground rules for discussions about feelings.
- ☐ Promote awareness of availability of qualified resources and support systems.
- ☐ Develop an infrastructure of available resources and best practices.
- ☐ Include local, state, and federal elected officials in an awareness program.
- ☐ Collaborate with local resources.
- ☐ Invest in peer support and chaplain support.
- ☐ Keep retirees engaged and connected.
- ☐ Develop a program to assist individuals with the retirement process and even in the period 6-12 months out from retirement.
- ☐ Identify counselors, chaplains, and therapists in your area who specialize in work-related issues specific to the fire service.
- ☐ Develop a mental health action plan to follow after major incidents.
- ☐ Remember and plan to acknowledge significant anniversary dates of major events.
- ☐ Leaders need to schedule follow-up check-ups after major incidents.

Connection with Social Supports – what support is available to the individual but also to the family

Information on Coping – accepting or being diagnosed with PTSD or other mental health challenges is hard to accept - the person is not the actual diagnosis, and as such does not accept the diagnosis as becoming a definition of the individual

Linkage with Collaborative Services – getting realistic, experienced help as soon as possible

CHAPTER 5: SUMMARY AND CALL TO ACTION

Given our world of increased violence and stressful calls, it is time to acknowledge and accept the need to focus on emotional wellness and resiliency. The repeated exposure to stressful events in the line of duty piled on top of a human being's everyday stressors can have a tremendous impact on first responders. We need to acknowledge this without judgment and we need to provide the support and treatment that our brothers and sisters deserve without fear of being judged or jeopardizing their positions.

Chiefs and their officers at all levels need to be accountable and take concrete action to change the culture and to work toward this goal of improving emotional and behavioral wellness in our people. This cultural change needs to be driven from the top down, with a solid demonstration of commitment from the command staff; it also needs to be driven from the bottom up in a grassroots approach to ensure that everyone in the organization has buy-in. This "sandwich approach" means that chiefs at the top, cadets at the bottom, and station-level officers in the middle must all push for this cultural change. Veteran officers are sometimes the largest instigators of the old way—they need to be the strongest proponents of the new way. Involvement at all ranks is critical to the implementation of any change initiative; we cannot state strongly enough how critical the implementation of this emotional and behavioral health initiative is to the future of the fire service, and the lives of its members and their families.

It is not acceptable for our brothers and sisters to choose this admirable service to society at the expense of their personal lives, as well as the lives of their families—the unspoken victims of this problem. It is time for the macho persona to end. We all know how strong and brave we are, but we need to also acknowledge the incredible stress and burden of being a first responder. It is up to each and everyone one of us to change our culture. We need every officer and chief to jump on board.

We can no longer afford to stick our heads in the sand, to look the other way, to pretend the issues don't exist. We will likely never be comfortable talking about behavioral health and suicide; however, it is our duty to educate ourselves and our departments and develop and implement emotional health and suicide prevention programs. It is our duty to ask the tough questions, have the difficult conversations, and serve as a role model in doing so. Our lives depend on it.

The purpose of this report was to take a stand on this issue, bring a level of awareness to the problem, and emphasize the importance of changing our culture. We have a saying in the fire service—risk a lot to save a lot. Isn't it time we do the same for ourselves?

APPENDIX

WHAT HAPPENS WHEN YOU CAN'T PROTECT THE ONES YOU LOVE?

By Patrick Kenny

How many of us got into the fire service thinking that we are capable of being modern day superheroes, maybe Superman? Don't laugh. Stay with me as you think of what your idea of the profession is all about. Did you join because you want to make a difference or that someday there might be a life present on this earth because of an action you contributed to or maybe even did yourself?

Not so funny now is it? Let's take it to the next level. As chief officers our number one goal is to protect our firefighters so they all go home to their loved ones. In cases where that has not occurred, for whatever reasons, people's careers and lives have been ruined.

I recently attended the Fire-Rescue International (FRI) in Denver where I sat in on three sessions recounting line of duty fatalities; two events occurred here in the United States and the other in the United Kingdom. All left me with the sick feeling of what negative impacts they had on the families of the deceased firefighters, the men and women of those departments and in particular the leaders of those organizations. The chief officers were no longer superheroes but now very much Clark Kent in their abilities to protect against harm's way.

Take it one step further. What if you personally as the chief officer, or someone in your organization, is struggling to protect a member of their immediate family from harm's way? We all have experienced this situation ourselves or know of those in our departments struggling with terminal illnesses of children, spouses or deaths of loved ones. How does that make the involved party feel when they can't protect the very one they loved? The potential for devastation, both personally and professionally, is as powerful as a line of duty death.

The presentations at FRI and my son Sean motivated me to share with you some painful lessons I learned from coming face to face with my own inability to protect someone I loved. I have wanted to write this article for over two years now and have started to do so many times, but always stopped short. Once you realize that you can only wear the cape successfully when the outcome is meant to be, not when you command that you need those lifesaving powers, do you realize just how powerless you truly are. Putting that in writing makes it even more real.

In May of 2004, I stood before those gathered at the annual symposium of the Illinois Fire Chiefs Association to receive their most prestigious award, that of Fire Chief of the Year. In attendance were family, friends, my officers, my wife Eileen and two of our sons Brendan and Patrick. At that same moment, my youngest son Sean was fighting a battle for his life in a drug rehabilitation center hundreds of miles away. He was not allowed to attend the event as he was days away from being released. Only a very few people in the department and practically no one in the audience that day knew the extent of Sean's illness.

I thought if the department knew of Sean's condition, they would have trouble understanding that mental illness had driven him to self medicate and thus become addicted to drugs. How could they possibly understand the whole mental illness concept and its ramifications when my wife and I were living in that environment every day and we felt lost? I knew my fellow chiefs had their own crosses to bear so why add to their plate?

That decision, in hindsight, was a huge mistake. The toll it took on me to try and keep up this "super" façade and the pressure it put on my few confidants, my administrative assistant, my deputy chief and a few trusted friends was, no matter how well intentioned, an error in judgment.

I can tell you what I felt that day of the award and continue to struggle to this day is that I was a fraud and a failure at what was my most important responsibility here on earth, being a father. I would have traded that award, while a wonderful honor, for my son being well. Frankly I would have traded my life for the same deal.

You see for some reason I was one of those people who really believed that I could "save the day". Whether it was my family or my fire department family I could always find a solution. Tell me I couldn't do something and then get out of my way while I proved you wrong! Sound familiar to anybody?

Sean was diagnosed with depression when he was only 5 years old. He lived a fairly normal life until he was entering his junior high school years and then the depression grew darker. By the start of his freshman year in high school he was so depressed he was hospitalized for what would be the first of countless psychiatric ward admittances over the next 6 years. He was subsequently diagnosed with obsessive compulsive disorder which is a disease that torments an individual's mind on a daily, if not hourly, basis. His quality of life was difficult at best.

The mental health system in this country is prehistoric. If you have had the unfortunate experience of dealing with that system either for one of your firefighters or a family member you know what I mean. Insurance coverage is minimal, help many times defined through more medication and authorized visits to a therapist are at a minimum. It is sad to admit but you are far better off to have your firefighter or family member diagnosed with a dreaded physical disease than a mental illness. Both cases reflect horrible situations but only the physical diseases are understood and accepted by the general public.

On June 3, 2006, Sean took his life with an intentional overdose of drugs. Sean had tried every medication known to man with no results other than harsh side effects. He tried all procedures, up to and including an experimental procedure with an implant in his chest just a couple of months before his suicide. We had been to Mayo Clinic nine months earlier where the doctors echoed his willingness to try anything. However, his medical history detailing the lack of success on all these different courses of treatment he had experienced throughout his life left them pessimistic as to his prognosis. My wife and I were told that long-term survival looked remote if a new intervention was not found. Sean finally saw no other choice to escape his pain but to go home to God.

During those years, my wife stayed at home to manage his care. Our whole family made many sacrifices. I kept thinking if I worked harder, taught additional classes on my own time to help pay for those uncovered medical expenses we could find the answer and I would save him. All of a sudden, on that horrible date, I was faced with the cruelest reality; I had failed to protect my son. If I couldn't

carry out that basic task how could I be expected to make decisions in the heat of battle to protect my firefighters?

After the funeral, I sat at home before returning to duty and actually asked myself if there would be a question of confidence from my firefighters as to my ability to lead. Who could blame them? "Is his head going to be where we need it to be"? Maybe it was time to find another profession where the possibility of losing another loved one was not so prominent in my thoughts.

This article is not intended to have you pity me or my family. We all either know of, or are experiencing, similar or worse situation in our lives and/or departments. The key is what are you doing to help those in need of psychological support including yourself?

Many of our states such as Illinois have answered the challenge of responding to firefighters in need immediately after a critical incident through a network of response teams (CISM) throughout the state consisting of highly dedicated trained professionals. You need to know how to contact those teams locally. What resources are available?

My concern speaks more to what is in place for those who suffer either from long-term effects from an incident or the root of the problem has nothing to do with an emergency response, as was my situation. So let's look at some lessons I learned that I hope can be of assistance to you.

The heroic persona of a firefighter naturally leads to the "tough it out" mentality. I can tell you from my experience there is no way to tough out losing your child, whether by accident or illness. As a priest friend of mine put it "you just joined a fraternity no one wants to belong to."

You need to seek professional help. Sure you can try to go back to "normal", whatever that is, but you will find the pain too overwhelming to handle alone. I can say for the very first time after Sean passed I actually had a glimpse of the deep depression he felt every day. The pain is just as real as the most imaginable physical injury one could endure. The same result will occur if there is no professional intervention and that is a deteriorating condition.

The first lesson learned is to find out if you and your department have a therapist you can turn to when faced with mental health concerns? I am talking about someone you have met, not just a name at the end of an employee assistance program business card. Make contact with that therapist and think about inviting them to come in once a year and meet with each shift. Let them meet the people in your department with the goal not to have a group therapy session but rather to get to know what exactly a firefighter does. How about offering ride time to that individual as another tool to benefit all?

I turned to a therapist that knew Sean and even more critical was familiar with the fire service. She made me face my demons of guilt and self doubt with an understanding that my profession and my own "heroic persona" was going to add to my difficulty to mentally begin the healing process. She hit me head on with putting my cape down and realizing not only was I not Superman, I also was not God and both those realities were okay!

Her experience with the fire service was instrumental in opening my heart to hear what she was saying and believing that she actually knew how I felt. As a chief officer you need to seek out mental

health professionals who at least have a basic knowledge of what your firefighters face on a daily basis. If the firefighter feels no connection with the therapist, the likelihood of success is severely diminished. From the therapist viewpoint, I would also imagine it is very difficult to treat someone you do not understand.

One month, almost to the date I lost my son, one of my firefighters had the courage to come to me with a very serious mental health challenge. Unfortunately, I knew exactly what he was struggling with, but more important I knew the trained professional to call. You never know when that call for help might be right outside your door at home or in the station.

The second lesson learned is you can impact how accepting the culture is in your department to deal with those battling mental health issues, whether it's a fellow firefighter or family member. By not sharing with my department to a larger degree my struggles and that of my son, I was sending the message to not talk about mental illness as if it was some dark secret and something to be ashamed of.

I am a big role model guy and here was an opportunity to model this progressive notion that mental health is just as important and real as the physical side. Instead of seizing that opportunity I shied away from it under the rationalization that I was "saving" everyone from that pain. I can tell you the reaction since my son's death has reinforced the notion that many in our profession suffer similar mental health challenges either in their own family or on their fire service family.

If I had been more public about my son's illness, I could have nurtured the culture in a positive way, not only in my department but neighboring organizations, to be open to mental health issues. Now I am not proposing that everyone bears their most private issues at roll call each morning but what I am saying is that the concern for and maintenance of the mental health side of our profession is lagging way behind the physical side. We better wake up and understand that it is a worthy challenger to our firefighters' well-being as well as our own. Just the increase in documented cases of Post Traumatic Stress Syndrome should have our antennae up.

It has been over two years now since I last hugged my son. The road to recovery is ongoing and while painful, I have made great strides. That is in no small part thanks to my faith, my therapist, my wife and sons but also the reaction of the members of the Hinsdale Fire Department and my friends throughout the fire service. From my administrative assistant, Marilyn Forslin, who watched out for my well being, to my Deputy Chief Mike Kelly who only now do I realize how many things never reached my desk until I was ready to handle them; you must have a support group in place. The existence of that support group for you or one of your people is the result of how your organizational culture looks at and reacts to those with mental health issues.

I have prayed to take something positive away from losing my son and so the final lesson learned is the most important and the one my son Sean taught me. Those who suffer from mental health challenges, no matter to what degree, are wonderful and courageous people. They are no more weak or responsible for their illnesses as is someone who is diagnosed with a terminal physical illness. Their disease is not something you can see like a tumor on an x-ray but it is just as real and needs support and treatment. As chief officers we must set up a system to provide help to those in need of treatment.

So I challenge you that if you are the one struggling, take off the cape for a moment and seek out the assistance you deserve. In addition, actively look for qualified professionals familiar with our profession who can provide the support you need personally or for the members of your department. Finally, make sure all know that your department values are clear as to supporting those in need of mental health assistance. You may not be Superman but you can contribute to this world being a little safer for all those you are responsible to care for and protect.

Sean and I both thank you.

I MADE THE CALL TO MAKE THINGS BETTER

By Scott Geiselhart

My name is Scott Geiselhart. I'm a 20-year veteran of the Frazee (MN) Fire Department, a father, an auto repair shop owner… And I am a PTSD, meth, and suicide survivor.

During my time as a firefighter, I had responded to countless calls, including auto extrication and ice water rescue, where I witnessed many deaths and other losses. It was all part of the job. But it affected me. I was angry all the time and yelled at my girlfriend and kids. I was having nightmares, flashbacks, angry outbursts, and was isolating myself! I was doing meth - a line an hour or more so I never would go to sleep and have nightmares! I thought I had a split personality!

In July of 2014, I had enough! I couldn't go on! I was so confused not knowing what was going on in my life! Why was I like this? I had to stop myself from hurting my family! I felt I needed to eliminate myself, they would be better off with me not hurting them! I went to my shop, found my favorite most reliable loaded revolver and put it to my head and pulled the trigger! The hammer came down and just clicked!

I threw the gun down in shock – it had never malfunctioned before. None of the rounds were touched!

I started to type words on my computer keyboard like "nightmares, yelling, flashbacks," etc. in a google search and PTSD filled the screen! I'd heard about PTSD (Post Traumatic Stress Disorder) before, but thought it was just something that affected the military; I didn't even know what the letters stood for.

I couldn't believe it – this condition was treatable! There was help out there. This wasn't something I had to live with forever. I went to tell my girlfriend and kids as fast as I could, but it must have seemed like I'd lost it. I was so excited to tell them I'd found an answer that I was yelling and they were scared of me and wouldn't listen.

I went back to my shop, heartbroken. I didn't know what else to do. I found a number for a suicide hotline, I called 12 times and no one answered. I called three other phone numbers that the fire department had provided, and they were disconnected. I called a police officer friend, and he said they were going to come pick me up. I didn't want to be taken to a mental hospital, so I decided I was going to try a few more numbers and then I was going to make my second suicide attempt. I called a local counseling center and they said they could see me in a week and a half. Finally, I had one last number left to call: 1-888-731-FIRE (3473) – the Fire/EMS Helpline.

Someone picked up right away, and after I told him what happened, he said, "Scott, we've got you."

Finally, someone was there, and understood what I was going through! It was as if they reached through the phone and were holding me in their hands! One of the amazing people on the other end of line was Mike Healy. Mike works with the National Volunteer Fire Council through American Addiction Centers to provide this free, confidential hotline to first responders and their families.

The next day, on Mike's recommendation, I was getting Eye Movement Desensitization and Reprocessing (EMDR) Therapy. EMDR is a type of psychotherapy that helps process negative memories through sounds or movements while you talk about the trauma. EMDR was incredible!

I'm back and loving life - no more nightmares and flashbacks! I walked away from meth and haven't been angry in 22 months! The peace I feel now is awesome! Now I'm able to share my experiences and help others by speaking out and informing emergency responders about PTSD, mental health and suicide awareness and prevention. I want other emergency responders to know if they are struggling, they are not alone and there is help available.

Watch more of Scott's story at https://youtu.be/NEBf_M_lr18

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RESOURCES

The Chemistry of Stress
https://www.nimh.nih.gov/health/publications/stress/index.shtml

IAFF Behavioral Health Program
http://client.prod.iaff.org/#page=behavioralhealth

Psychological First Aid--Field Operations Guide (2nd Edition)
https://dmh.mo.gov/docs/diroffice/disaster/pfafieldoperationsguide2ndedition.pdf

National Alliance on Mental Illness
https://www.nami.org/Get-Involved/Law-Enforcement-and-Mental-Health

National Fallen Firefighters Foundation
https://www.everyonegoeshome.com
https://www.firehero.org

National Volunteer Fire Council – Share the Load Program
http://www.nvfc.org/programs/share-the-load-program/

The NFPA November 2016 report, "Firefighter Suicide and Behavioral Health are Becoming a Concern to the Fire Service," includes a comprehensive list of resources and links.
http://www.nfpa.org/FFSuicideAwareness

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TO THE FOLLOWING ORGANIZATIONS FOR THEIR SUPPORT ON THIS PROJECT.

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