



DETROIT FIRE DEPARTMENT ENVIRONMENTAL ASSESSMENT SUMMARY



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City of Detroit



CITY OF DETROIT

Fire Department Environmental Assessment

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INTRODUCTION

Serving for 161 years, the mission of the Detroit Fire Department (DFD) has been to provide a safe environment for City of Detroit residents and visitors through public education, enforcement of fire codes, emergency preparedness and deployment of efficient emergency response resources. Ignoring COVID 19 danger, these brave women and men reported in person to their assigned fire houses and did their jobs skillfully and faithfully. In 2020 Detroit firefighters responded to 26,257 fire runs, and 22,508 emergency medical runs. Emergency Medical Service (EMS) division paramedics responded to 134,232 medical runs.

The United States Fire Administration posted in January, 2018 an article written by Messrs, Jahnke, Poston, Haddock and Murphy entitled “Fire Fighting and Mental Health----The Effect Repeated Exposure to Trauma on Firefighters” (2016). The posted abstract reported

“Across the country, firefighters are responding to fewer fires but are increasingly called upon to provide emergency medical services, perform search and rescue missions and react to hazardous material incidents and natural disasters. They come across a wide variety of tragic situations that play out in or around their homes, along highways and in every other conceivable part of their communities. The cumulative effect of regularly caring for the broken bodies and wounded minds of victims and their families is thought to have a negative psychological impact on firefighters own mental health. Previous studies have looked at firefighter mental health challenges in the context of post-traumatic stress syndrome (PTSD) which relies on an assessment of instruments attuned to one particular trauma event even though it is more common for firefighters to experience a negative mental health impact from a series of traumatic events rather than from a single event.



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Evidence from previous studies shows that rates of depression among fire and EMS personnel are higher than the general population. Firefighters have higher rates of alcohol use in binge drinking compared to the general public. There is a possible connection between risky drinking behaviors and PTSD. Firefighters experience secondary trauma or compassion fatigue from repeated exposure to trauma. Symptoms of repeated exposure to traumatic events for most firefighters include desensitization, irritability, cynicism and intrusive flashbacks.

Earlier this year and over the course of one week two incidents of drunken-driving while on duty occurred within the DFD. In response Mayor Mike Duggan in partnership with Firefighter union leadership both local and international launched an independent environmental audit and a review of DFD policies and the employee assistance programming.

Two hundred and twenty members of DFD including EMS technicians were interviewed by City of Detroit Human Resource Department professionals. The questionnaire to which the participants responded was developed by the City of Detroit Human Resource Department and approved by DFD union and executive department leadership. Not all questions and responses are discussed in this report. The entire set of questions are contained in the appendix.



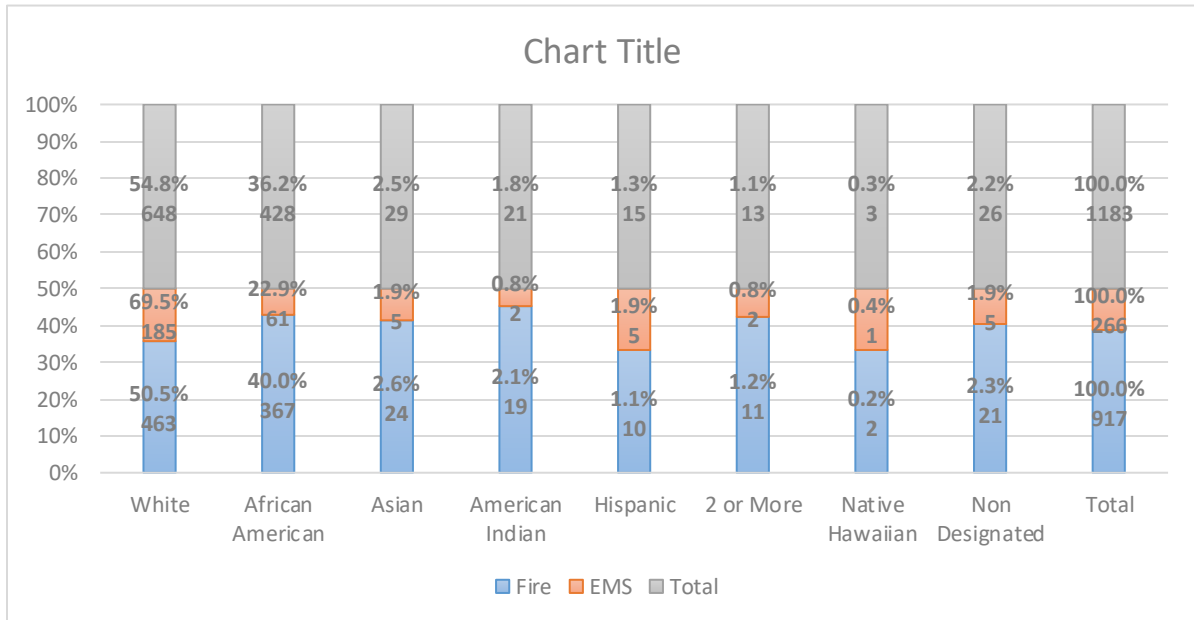
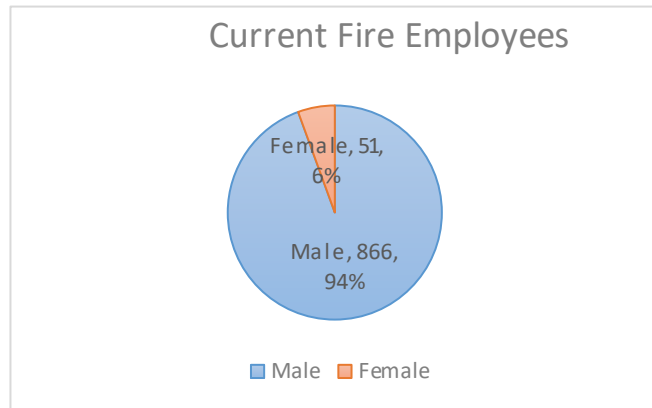
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SECTION I: DEPARTMENT DEMOGRAPHICS

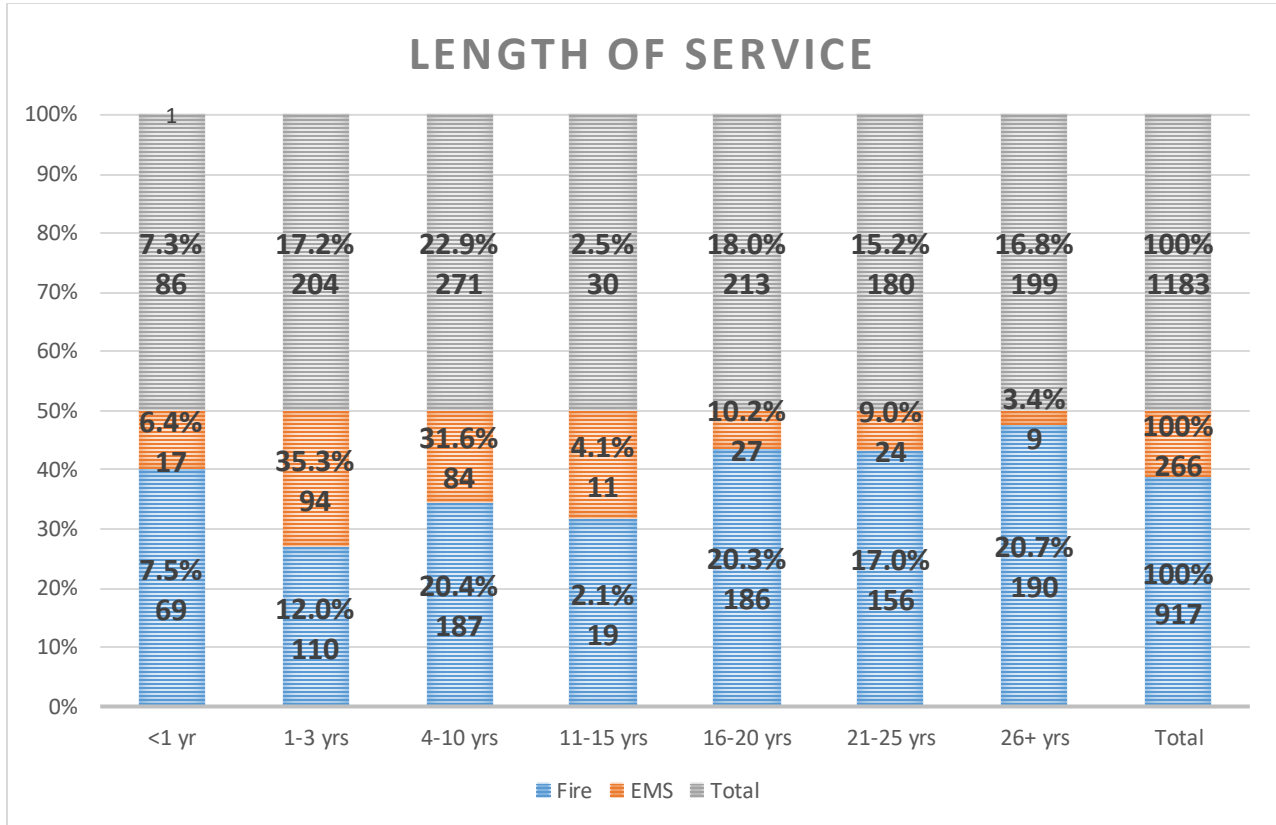
Included below are the current demographics of the department to provide insight into the composition of the employee population.

Total Employees: 1183
Fire: 917 (77.5%)
EMS: 266 (22.5%)





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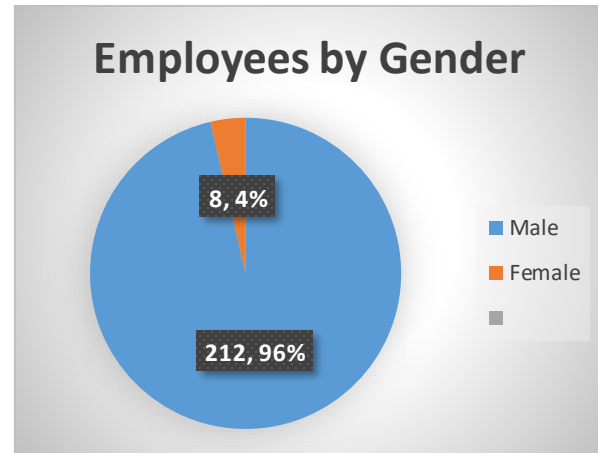
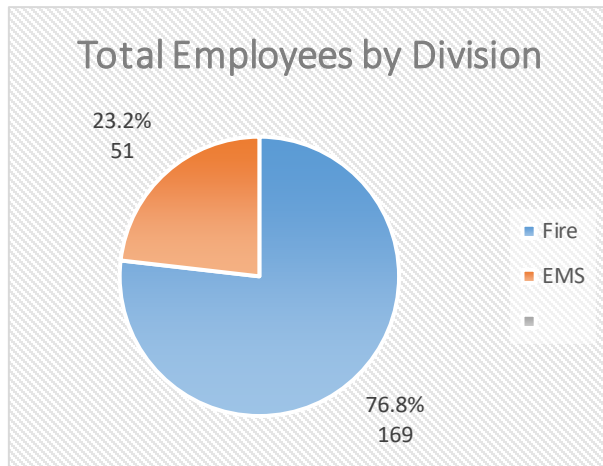




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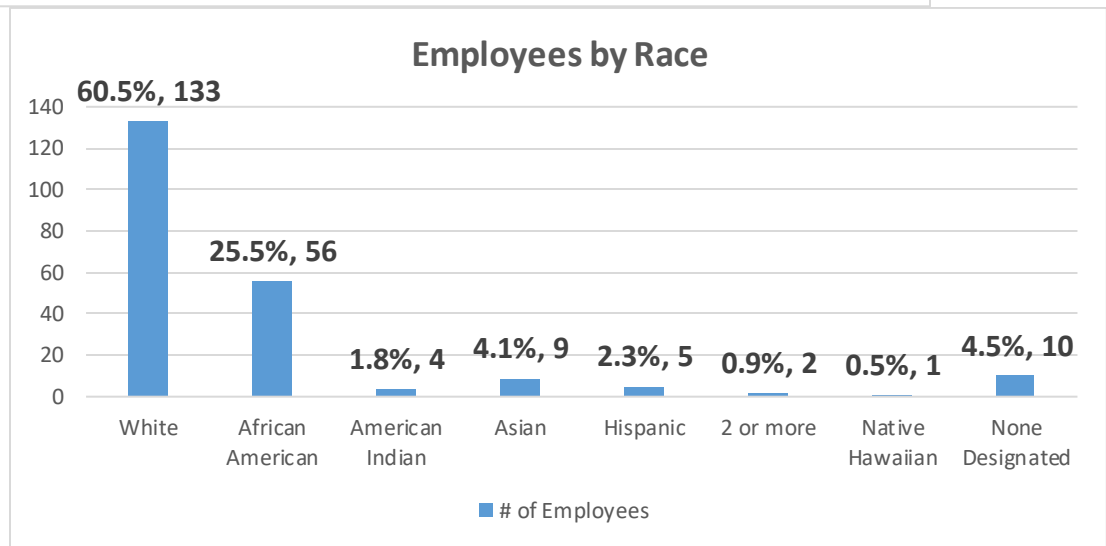
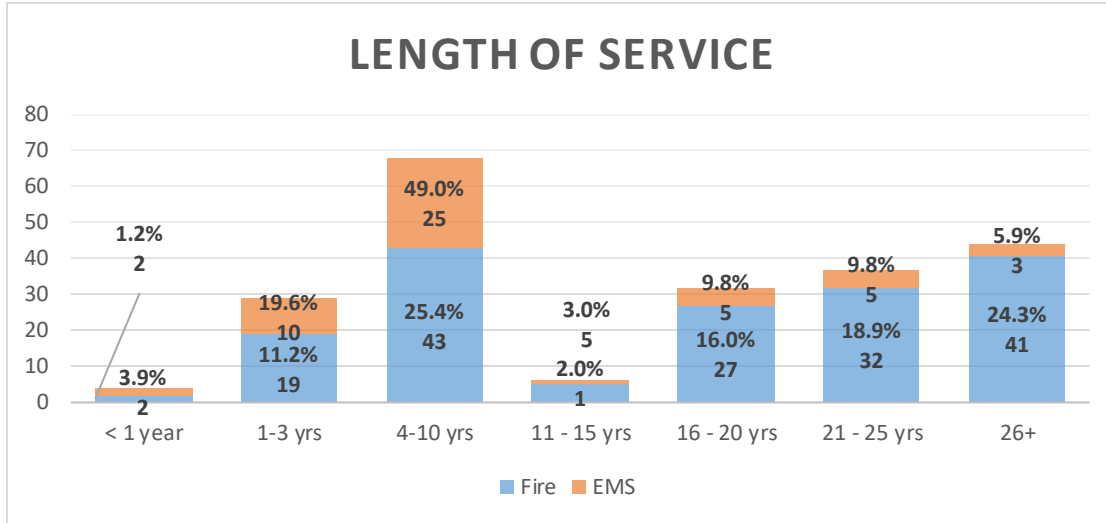
DEMOGRAPHICS OF EMPLOYEES INTERVIEWED

Listed below are the demographics of the employees that participated in the interview assessments:





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SECTION II: INTERVIEW DETAIL (Broken Down By Key Questions)

1. People view firefighters and medics as heroes, are you proud of your calling?

Overwhelmingly i.e. almost to a person interviewees responded that they are proud of their calling/profession.

2. Do you feel that the recent highly publicized events have put the Department in a poor light?

Overwhelmingly i.e. almost to a person interviewees indicated that the past yet fairly recent events put the Department in a poor light

3. What's your opinion about the work environment (i.e. work location, co-workers, immediate supervisor)?

40% of persons interviewed indicated they liked their work locations, enjoyed their co-workers and liked their immediate supervisor. Most interviewees while echoing their fellow's opinion regarding work location, comradeship and the positive impact of immediate supervision, voiced communication and scheduling concerns.

4. What are some behaviors that leaders in the department need to change to improve the work environment?

130 (59%) of the 220 interviewees voiced concerns about morale and leadership visibility. Scheduling, communication and impactful employee recognition programming were also reported



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5. Are you familiar with the City's Employee Assistance Program?

More than half of the respondents expressed no awareness of employee assistance programs.

6. How likely are you to use EAP for managing stress?

Those respondents who were aware of employee assistance programming did indicate that they would use the services if necessary.

7. If you recognize that one of your colleagues is experiencing stress that could compromise safety, do you feel empowered to notify your supervisor?

Most employees indicated that they feel empowered to notify their supervisor but, would more than likely would deal with it with the individual. If that was not successful, they would escalate to their supervisor/leadership. Numerous individuals mentioned that they would refer them to PGU (Lenette Woods) for support.

8. Do you feel that you have the resources, gear and equipment needed to do your job?

75% of employees were satisfied they were given all the resources, gear and equipment necessary to do their jobs. A significant minority while acknowledging resources had greatly improved from years past still felt supply chain and ancillary equipment upgrades should be considered.

9. Do you believe that the Department Leadership has a sincere interest in the well-being of their employees?

Almost half of the respondents expressed a desire for more and better communication and more frequent visits from leadership. Site based leadership was referenced positively.



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10. Are you familiar with the Department Directives around Safe Vehicle operations and Fire Ground Safety Protocols?

Overwhelmingly i.e. almost to a person respondents reported deep familiarity with safe vehicle operations and fire ground safety protocols.

11. Are employees encouraged to promptly report workplace incidents, injuries and illnesses?

Overwhelmingly i.e. almost to a person respondents reported positive encouragement to report workplace incidents injuries and illness. Significantly respondents also reported that accidents and injuries were properly investigated.

12. Have you ever seen drinking/drug use in any of the Fire houses that you have worked out of?

Overwhelmingly i.e. almost to a person reported never seen drug use among any of their colleagues. Almost 60% of the respondents reported not seeing any drinking or alcohol abuse. While it's true that 40% of respondents reported seeing drinking most qualified their statements suggesting that this practice was something witnessed only in the past.

13. Do you feel comfortable with bringing potential substance abuse issues to leadership?

More than 75% of respondents indicated they would feel comfortable bringing potential substance abuse issues to leadership. A significant number of respondents indicated that they would first try to deal with the issue colleague to colleague before going to leadership. A small minority indicated that they would reach out to one of the peer counselors and direct that person to the colleague they believed was in trouble.



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14. Do you believe the Department provides sufficient flexibility to help you balance your work life and personal life?

More than half of the respondents felt there was in their life, sufficient work life/personal balance. Significantly many respondents expressed a desire for more scheduling flexibility director related to stress management issues.

15. Do you feel comfortable raising an ethical concern to your supervisor or leadership?

More than 80% of the respondents felt like they could raise ethical concerns with their supervisor and with leadership in general. Most of the remaining respondents indicated they would handle the matter colleague to colleague before going to leadership. Overwhelmingly i.e. almost to a person respondents were integrity driven.



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SECTION III. METHODOLOGY

The environmental audit task was asked to assess the level of leadership support members of the fire fighter/emergency medical first responder community perceived was provided by the Detroit Fire Department (DFD) and the Emergency Medical Services (EMS) division, executive leadership teams.

Though the scope of the audit was limited, the findings and recommendations, based on the number of interview participants and the geographic distribution of the home firehouses, are significant. The following documents were reviewed as a part of the audit process:

1. Policies
 - a. DFD attendance control policy
 - b. DFD standard operating procedure firefighting division requirements
 - c. DFD substance abuse policy

2. DFD Policy Directives—1.11; 1.111. 1.92; 10.91; 10.6; 10.8; 10.19; 10.23; 10.25; 10.38; 11.1; 11.2; 11.3; 11.4; 11.12; 11.13; 14.1; 14.2; 14.4; 14.6; 14.11; 14.15; 15.11; 16.4.22; 16.4.25

3. Human Resource Documents
 - a. EMS discipline records 2019 – 2020
 - b. DFD discipline records 2019 – 2020
 - c. Active Duty Death records 2019 – 2020
 - d. City of Detroit 2019 Employee Engagement Survey

4. Training Materials
 - a. DFD department training curriculum
 - b. 2018 – 2019 – 2020 annual training reports



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5. Accident Reports

- a. DFD vehicle accident reports 2018 – 2021
- b. EMS vehicle accident reports 2018 – 2021

6. Other

- a. Detroit Police Department sixth precinct and ninth precinct environmental audits for both form and substance.
- b. Detroit Fire Fighters Association/City of Detroit Master Agreement
- c. Emergency Medical Service Officers Association/City of Detroit Master Agreement

Two hundred twenty interviews were conducted. Participants included 169 DFD firefighters and 51 EMS paramedics. Detailed and expert facility and equipment inspections were not done. It is strongly recommended that such inspections occur and the findings shared with frontline team members, DFD, EMS, and Union executive leadership.

Participation in the interview process was voluntary. The questions as presented were open ended, designed to stimulate conversational responses reflecting an interviewee's opinions beliefs and concerns.



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SECTION IV: SUMMARY/RECOMMENDATIONS

Key Findings

- 1. The DFD/EMS voluntary peer to peer counseling program must be more robust.**
- 2. The peer to peer counseling program must at a minimum be staffed by four trained and certified DFD/EMS department members.**
- 3. The four person peer to peer counseling program should be modeled on the Boston Fire Department program using the DFD Personal Guidance Unit (PGU) as a possible foundation.**
- 4. Lenette Woods is a brilliant peer support program coordinator/ counselor but she is a single person, not a program nor a department.**
- 5. Leave policies need to be reviewed in the context of the newly constructed employee assistance program, recognizing current policies will not support meaningful substance abuse recovery opportunities.**

Please look at the responses to questions five, six and seven. The vast majority of interviewees both DFD and EMS did not know about the City of Detroit's employee assistance program. Two members of the audit team made visits to various firehouses in preparation for the environmental audit process.

Audit team members wanted to make sure their DFD and EMS colleagues understood that their participation in the audit process was voluntary and that all responses would be confidential. When the subject of employee assistance programming was raised invariably first responders mentioned Lenette Woods. Praise for and unqualified respect was given to Ms. Woods. Persons recognized her as an experienced, dedicated, tireless peer counselor who worked diligently to help her colleagues ease their suffering. Ms. Woods is the only paid member of the otherwise volunteer peer counseling group serving the DFD/EMS peer support program.



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The DFD budget for its Peer to Peer Counseling program is little less than \$79,000.00. Conversely the Boston Fire Department Peer to Peer counseling program budget is a little less than \$700,000.00.

There has to be developed an extremely robust appropriately funded trained firefighter and emergency medical service peer counseling and assistance program. The current DFD/EMS peer counseling provides a foundation. The required modifications to the current DFD/EMS peer to peer counseling program need to be implemented after investigation of the Boston Fire Department program, in consultation with the International Association of firefighters. Designated persons ought to be given 60 days to investigate and construct the program with implementation for some time during the summer months of 2021. Detroit City Council approval of the supplementary budget request will be required.

The Ruderman Family Foundation White Paper on Mental Health and Suicide of first responders dated April 20, 2018 says on page 7,

"Police and firefighters, when compared to the general population are at heightened risk for depression, posttraumatic stress disorder and suicide. These findings are also relevant for EMS workers but since many EMS workers are also firefighters these two professions are often undistinguished in the research. First responders witness for on a daily basis. These men and women including firefighters, law enforcement personnel and emergency medical service workers have front row seats to the horrendous aftermath of natural disasters, terrorist attacks, violent domestic disputes, traffic accidents and more. Many first responders have military experience and therefore their experience as first responders pile onto a career that is already rife with trauma. These professionals embody astounding bravery and resilience, but at the end of the day, they are only human.

Constant exposure to death and destruction exerts a psychological toll on first responders, resulting in posttraumatic stress disorder, substance abuse, depression and sometimes suicide. In addition to documenting the prevalence of posttraumatic stress disorder among firefighters, researchers have also noted high



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rates of binge and hazardous drinking behavior. One research team examined drinking among female firefighters and found that 40% reported binge drinking during the previous month and 16.5% of female firefighters who use alcohol screen positive for problem drinking behaviors. Another study included both male and female firefighters and found even higher rates of binge and hazardous drinking 58% and 14% respectively. These same researchers (Carey, Al-Zaiti, Dean, Sessann & Finnell, 2011) found a depression rate of 11% in their sample of 112 firefighters compared to 6.7 in the general United States population of adults 18 and over. The consequences of depression, substance abuse and posttraumatic stress syndrome are severe.”

The Ruderman Family Foundation White Paper April, 2018 is included in the appendix of this report. Designated DFD/EMS employee assistance program developers should read this paper carefully. It is the strong and unequivocal recommendation of the audit team that the Boston Fire Department first responder assistance program cited by the authors, be investigated. The authors believe the Boston Fire Department program is the benchmark against which all other first responder employee assistance programs should be measured.

The vast majority of interviewees are familiar with the department safe vehicle protocols, feel empowered to report accidents and feel like all accidents are properly investigated. Reporting accidents as they occur without fear of retaliation is a positive. Creating and sustaining a culture where service providers feel safe to report accidents is often difficult. DFD/EMS executive leadership should ask “Why do our team members feel safe reporting accidents and why do they feel the reported accidents are properly investigated?” Perhaps the leadership behaviors that sustain this positive could be imported to other areas of work.

Please note questions 12 and 13. It is interesting to note the majority of respondents reported they had not seen any drinking or drug use among colleagues. The contributors to this report respect the veracity of all of the respondents. Many interviewees believe alcohol drinking on the job is a thing of the past. Conversely many respondents believe alcohol abuse remains a problem that needs a solution. Coupled with the fact that many respondents feel like the



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department does not provide sufficient flexibility to help balance work life and personal life it is clear, the necessity to provide more and better support to Fire and EMS first responders is necessary.

The final key question presented is extremely important. 86.8% of all respondents reported they would feel comfortable reporting an ethical concern to their supervisor or leadership. This may be a testament to the quality of on-site leadership present in DFD firehouses. This overwhelmingly positive response is a reflection of DFD/EMS culture that frontline personnel consider to be high functioning, dependable and long-standing. DFD executive and EMS division leadership along with union leadership should spend some time understanding how it is that frontline team members regularly and fearlessly report accidents and also feel like ethical concerns can be safely raised. DFD/EMS leadership ought to embrace the fact that not every part of the culture is broken.



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APPENDIX A

CURRENT PERSONAL GUIDANCE UNIT (PGU)/EMPLOYEE ASSISTANCE PROGRAM (EAP)

1.0 PURPOSE

DFD currently has a Peer Support Program to prevent or lessen the potential negative impact of stress upon a member by providing emotional support, information and assistance. This support is provided to personnel and family, through one-on-one discussion, active listening, immediate support and post incident follow-up. The peer support team consists of individuals within the Detroit Fire Department who have been specifically trained in stress management and crisis intervention. All peer supporters are certified by International Critical Incident Stress Foundation Incorporated or any designated certified training program approved by the Department. Peer Supporters who are licensed therapists/mental health counselors, social workers, psychiatrist/psychologist, clergy, chiefs, captains, sergeants, lieutenants or union members are not working in those capacities as Peer Supporters.

2.0 SCOPE

All DFD Employees.

3.0 DEFINITIONS

Assessment: The process of making a judgment about information gathered during meeting with peer.

Critical Incidents: A sudden event, such as, responding to an injury sickness or death of a family member, co-worker(s), pediatric injury/death, or mass casualty incident that may cause profound emotions.

Mental Health Professionals: Person who possesses a limited license or full license with a concentration in mental health from the State of Michigan.



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On-Call: Being available on a voluntary basis to respond to stress related incidents after regular work hours and on weekends.

Peer Support Committee: The committee shall consist of representatives from each Department division: EMS/Fire Management, Human Resources, Communications, Core of Chaplains, Guidance counselor, Medical Director and a member from the DFFA Board of Executives or designee.

Peer Support Coordinator: The primary liaison between the Peer Supporters, outside referral sources, the Peer Support Committee, and Fire/EMS management.

Peer Supporter: Provides support and assistance to employees in times of stress and crisis as part of a Peer Support Team.

Peer Support Team Members: This is made up of a Peer Support Coordinator, and Peer Supporters.

Referral: The process of directing the peer to appropriate professional service(s) that are available and/or additional resources that may be needed.

Referral Program: Established to assist employees in dealing with problems such as domestic, financial, health, or job related difficulties, and to enable the employee to recognize and resolve the unfavorable reactions to that emotion or stress.

Serious Injury: Any injury resulting in a Code 1 transport, or resulting in an admittance to the hospital.

4.0 PROCEDURES/GUIDELINES & INFORMATION

Peer Support Program Oversight

The Peer Support Program and process shall be managed by the Peer Support Coordinator. The Peer Support Coordinator shall report to the Peer Support Committee. The Peer Support Committee shall be the ultimate authority regarding all Peer Support Process



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concerns/decisions. The Peer Support Coordinator shall work under the authority of the Peer Support Committee.

The Peer Support Committee responsibilities shall include:

- A. Maintain adherence to the Peer Support Program Standard Operating Procedures.
- B. Distribute, collect, review, and approve peer supporter applications.
- C. Evaluate program operations and modify as needed.
- D. Provide administrative support and explore funding options when necessary.

Peer Support Program

- A. Provide emotional support during and after times of personal or professional crisis to employees who express a need for assistance, or for whom supervisory staff/coworker feel could benefit from program involvement.
- B. Promote trust, allow appropriate anonymity and preserve confidentiality for employees utilizing the program.
- C. Develop peer support personnel who can identify personal conflicts and provide guidance or referral to professional or alternate resources as required.
- D. Provide personnel to listen, assess, and whenever necessary, refer to professional assistance to employees and their families during times of trauma, grief, or other personal and professional problems.

Peer Support Program Coordinator

Shall function as the primary liaison between the Peer Supporters, outside referral sources, the Peer Support Committee, and Fire/EMS management.



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The Peer Support Coordinator responsibilities shall include:

- A. General supervision of the program
- B. Recruiting and coordinating the screening of the peer support applicants with the assistance of the peer support committee members.
- C. Identifying and coordinating the appropriate training for the personnel selected to become Peer Supporters, and documenting and maintaining all records pertinent to such training.
- D. Ensure all employees are aware of the program through written memorandums, presentations and other literature, as may be developed.
- E. Preparing and disseminating a list of resources for additional support and guidance outside of the Department.
- F. Identify and coordinate the appropriate training, documentation and records for all peer supporters.
- G. Maintaining monthly statistical data of reported contacts by Peer Support staff for program evaluation purposes and forwarding to the Program Advisor.
- H. Acting as the liaison for peer support referrals.
- I. Providing guidance and assistance to Peer Supporters when problems or questions arise.
- J. Ensuring that in situations where an employee needs protection under the privileged communication statute, referrals are made only to psychiatrist(s) of which are contracted with the City of Detroit and identified through Human Resources.
- K. Assign Peer Supporters to critical incidents based on the identified needs.



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- L. Notify Central Office every time he/she is responding to or leaving an incident requiring peer support.
- M. Check in with Central Office to avoid a wellness check after being on an incident scene for 2 hours.

Peer Supporters

The Peer Supporter provides voluntary support and assistance to employees in the time of stress and crisis. Peer Supporters shall always respond to incidents in teams of two.

The Peer Supporter's responsibilities shall include:

- A. Informing all peers seeking assistance that the Peer Supporter will maintain confidentiality subject to the exceptions defined in this document.
- B. Advising a peer that any action of self-injury or injury to others cannot go unreported.
- C. Advising other parties seeking information about discussions shared between a peer and Peer Supporter that the information is confidential.
- D. Providing short-term supportive assistance and or referral, for employees involved in the Peer Support program, within the scope of their ability, knowledge and training.
- E. Making additional referrals for assistance when deemed appropriate.
- F. Establishing contact with, and offering assistance to, those employees who self-refer, or are referred by supervisory personnel.
- G. Being available for referrals during designated working and non-working hours.
- H. Responding to the scene of a critical incident on a volunteer basis while on-call if requested by the Incident Commander.



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- I. Notifying the Peer Support Coordinator, EMS/Fire Supervisor in charge of the employee if unable to handle an escalating situation.
- J. Being available on an on-call basis for a 30 day period on a rotating basis.
- K. Notify Central Office every time he/she is responding to or leaving an incident requiring peer support.
- L. Check in with Central Office to avoid a wellness check after being on an incident scene for 2 hours.

On-Call Peer Support

There shall always be four (4) personnel on-call for peer support. Each on-call Peer Support employee shall be issued a department radio for their 30 day on-call period.

Each on-call Peer Support employee must enter their department radio into the Daily Radio Inventory smartsheet for tracking purposes and accountability.

Peer Supporter Notification

Peer Support Team members will be called to the scene where support is needed during their assigned times. This will include all Critical Incidents and other Call outs as defined in this section.

1. Critical incidents are defined as a sudden event, such as, responding to an injury, sickness or death of a family member, co-worker(s), pediatric injury/death, or mass casualty incident that may cause profound emotional reactions.
2. Critical incidents that require a Peer Support Team Member response shall include, but are not limited to:
 - a. When an employee witnesses another employee's death or serious injury;
 - b. Line of duty death;
 - c. When an employee has been assaulted/held hostage;



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- d. Infant/pediatric death or serious injury;
- e. When an employee has witnessed a suicide/homicide;
- f. Mass casualty incident; and,
- g. Any request for the Peer Support Coordinator, Chaplain, Peer Support.

3. Procedure for Call Outs:

- a. The Communications Division will make verbal notice by phone and by Smartsheet notification to the Peer Support Coordinator (1108) and Chaplain (1200), and to the on-call Peer Support team members.
- b. Peer Support team members that are assigned for the current week will respond upon notification.
- c. Team members should respond to notifications by calling Communications to confirm enroute to the incident.
- d. Two (2) team members will respond to each incident.
- e. Team members will confirm arriving on scene and clearing of the scene with Central Office/Dispatch.
- f. When an individual has been seen by the Peer Supporter, Chaplain or Personal Guidance Counselor and further care is needed, it is the responsibility of the Supporters, Chaplaincy and Counselor to;
 - i. **Fire Division Personnel (Fire fighters)**- Discussion must be had with house boss to have individual or unit out of service. Chief of Department must be contacted regarding detail of individual or crew (follow up process)



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- ii. **Communications (Dispatchers)**-Discussion must be had with Sergeant on floor, Assistant Chief and Chief of Communications regarding individual. (time available to be used, follow up process)

- iii. **Emergency Medical Service (EMS)**-Discussion must be had with sector Lieutenant/Shift Captain for crew, individual status (Assistant Chief/Chief of EMS how time will be carried, follow up process)

- g. A Peer Supporter may continue to meet with an individual employee outside of the Call Out process if the individual employee requests to meet and the Peer Supporter is available.

- h. If an individual employee contacts the Peer Supporter Coordinator and requests to meet with a Peer Supporter, the Peer Supporter Coordinator will make that assignment.

- i. Peer Supporters will not be utilized during their working hours to respond to a call out if contacted by a Peer. The PGU Counselor will provide the Peer with a list of available Peer Supporters to speak with or meet with.

Peer Support Team Assignments

Peer Supporter assignments will be made weekly in accordance with availability. Peer Support Team Members are expected to volunteer during *non-working hours*.

1. There will be four (4) Peer Support Team Members assigned each week that will receive notifications from Communications for incident response.

2. Two (2) Peer Support Team Members will respond to each incident to maintain safety.



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Confidentiality

The Detroit Fire Department recognizes that the dialogue between members of the peer support team and those individuals that utilize the peer support program is considered confidential, which is essential for the success of the program. A Peer Supporter cannot be ordered to break confidentiality by anyone, including any Labor Union representatives. At times, the Peer Supporter may request the member's permission to speak to a third-party about the issue. Third parties may include other Peer Supporters or mental health professionals. Breach of confidentiality by a Peer Supporter will result in immediate dismissal from the program as a Peer Supporter. Further discipline may be issued at the discretion of the Executive Fire Commissioner.

Peer Supporter Removal

Any Peer Supporter that fails to abide by the program policies and objectives may be removed from the Peer Support Team by the Peer Support Coordinator. Immediate removal will occur for breaches of confidentiality.

Peer Supporters can also be voluntarily removed provided that said Peer Supporter provides a removal request letter to the Peer Support Coordinator.

Peer Supporters must always maintain confidentiality, even after no longer serving as a Peer Supporter.

Exceptions to confidentiality:

- 1. Danger to self**
- 2. Danger to others**
- 3. Suspected child abuse**
- 4. Suspected elder abuse**
- 5. Domestic violence**



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6. In other cases where law or department policy requires disclosure

7. Where disclosure is approved by the member

Central Office

Central Office shall keep a Peer Support Activity Log. Every time Central Office is notified that a Peer Support Team member is responding to an incident; the time, location, and name of the Peer Support Team member shall be noted.

Central Office shall call the Peer Support Team member after two hours unless the Peer Support Team member checks in with Central Office beforehand. This is a wellness check.

Central Office shall also note the time that the Peer Support Team member is clearing the incident.

Peer Support Requests

Any employee can request peer support for either themselves or for any other employee.

Anyone requesting peer support shall find the contact information in **Forms and Links** under Department Forms and Information. All peer support requests shall remain confidential.



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APPENDIX B

DFD ASSESSMENT QUESTIONS

SCRIPT

Hello, my name is _____ of the HR Department. We are meeting with you and others over the next few days to get a better understanding of working conditions in fire stations throughout the City and employees overall well-being. These meetings are not to call individuals out, place blame, nor retaliate against anyone. Our goal is to understand the working conditions of firefighters and medics, and the root cause of any deficiencies. We will use this information to develop an action plan to support the men and women of the Fire Department. We recognize that you risk your lives on a daily basis and we commend you for all you do to protect and save the lives of families and our residents.

The interview will take approximately __ minutes. _____ is here to take notes during the interview. Your feedback is very important to us. It will assist us with developing a plan to ensure that we are providing the appropriate resources to support our employees. Answer the questions based on your own experience, where you have first-hand knowledge. To ensure anonymity, individual responses will not be shared with the Fire department. We will provide a summary report.

Before we start the interview, do you have any questions?

Employee Pension #: _____ **Engine #:** _____

1. How long have you been working for the Fire Department? _____
2. What are some of the things you like about your job?
3. Fire/Emergency Medical service is an honorable vocation; how did you decide on your profession?



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- 4. People view firefighters and medics as heroes, are you proud of your calling?
- 5. Do you feel recent highly publicized events have put the Department in a poor light?
- 6. How do you respond when people denigrate all firefighters/medics for the actions of a few?
- 7. What’s your opinion about the work environment (i.e. work location, co-workers, immediate supervisor)?
- 8. What are some of the behaviors that leaders in the department need to change to improve the work environment?
- 9. Your role can be extremely stressful. How do you cope with stress?
- 10. How do you know when you are experiencing stress? What are some indicators?
- 11. Are you familiar with the city’s Employee Assistance Program?

Yes No

- 12. How likely are you to use EAP for managing stress?

_____ Unlikely _____ Likely _____ Neutral _____ Extremely Likely

- 13. If you recognize that one of your colleagues is experiencing stress that could compromise safety do you feel empowered to notify your supervisor?



CITY OF DETROIT Fire Department Environmental Assessment

14. Do you feel that you have the resources, gear and equipment needed to do your job?

Yes No

a. If no, what additional resources are needed?

15. Do you believe department leadership has a sincere interest in the well-being of employees?

Yes No

16. Are you familiar with Department Directives around safe vehicle operations and Fire ground safety protocols?

Yes No

Why are the safe vehicle and Fire ground safety protocols important?

17. Are employees encouraged to promptly report workplace incidents, injuries and illnesses?

Yes No

a. Are they properly investigated?

18. Have you ever seen drinking/drug use in any of the Fire houses that you have worked out of?

Yes No

a. If yes, please describe what you have seen.

b. In what context did this occur? (e.g. after a fire run, in-between fire runs, around the table at dinner, etc.)



CITY OF DETROIT
Fire Department Environmental Assessment

19. If not, have you ever heard of this occurring from other Fire employees?
a. If so, what was the situation they may have shared?
20. Do you feel comfortable with bringing potential substance abuse issues to leadership?
21. Do you believe the Department provides sufficient flexibility to help you balance your work life and personal life?
- Yes No
- a. If no, please provide recommendations on how we may be able to provide support.
22. Do you feel comfortable raising an ethical concern to your supervisor or leadership?
- Yes No
- a. If not, Why?
23. Would you describe how the training you received has helped you perform your job better?
24. What are the types of training you would like to see offered?
25. Is there any additional information you would like to share to provide additional insight on how we can provide additional resources to support the emotional well-being of our employees?

APPENDIX C

THE RUDERMAN WHITE PAPER ON MENTAL HEALTH AND SUICIDE OF FIRST RESPONDERS



The Ruderman White Paper on
Mental Health and Suicide of First
Responders

Miriam Heyman, PhD

Jeff Dill, MA, NBCC

Robert Douglas, DCC

April 2018

The Ruderman Family Foundation

At the Ruderman Family Foundation, raise the profile of issues related to disability, inclusion, and mental health. We believe that full inclusion of people with disabilities is not a matter of charity, but of civil rights. Mental health and suicide among first responders is a topic that needs to be explicitly and frequently addressed by media outlets, policy makers, first responder professionals, and the public at large. We hope that this White Paper will spark a conversation about mental health that will ultimately facilitate access to services for all people, including first responders.

Our Mission

The Ruderman Family Foundation believes that inclusion and understanding of all people is essential to a fair and flourishing community. Guided by our Jewish values, we support effective programs, innovative partnerships, and a dynamic approach to philanthropy in our core area of interest: advocating for and advancing the inclusion of people with disabilities in our society. The Foundation provides funding, leadership, expertise and insight in the U.S. and Israel, with offices in both countries. Visit us at: <http://www.rudermanfoundation.org>

Primary Contributors

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span. She has published research findings related to employment and the well-being of people with disabilities in several journals, including the Journal of Intellectual Disability Research, Early Child Development and Care, and The Journal of Vocational Rehabilitation. Miriam is also an adjunct faculty member at Boston College, where she teaches undergraduate and graduate psychology courses.

Jeff Dill founded the Firefighter Behavioral Health Alliance (FBHA) in 2011. Jeff travels the United States and Canada holding workshops to teach firefighters and EMS about behavioral health awareness and suicide prevention. FBHA is the only known organization that collects and validates data on firefighter and EMT suicides across the United States. In addition, FBHA holds classes for counselors / chaplains, family members, and first responders who are preparing for retirement. Jeff holds a Master's Degree in Counseling from Argosy University in Illinois, He is a Licensed Professional Counselor, and a retired Captain at Palatine Rural Fire Protection District in Inverness, Illinois.

Robert E. Douglas, Jr. is the Executive Director and Founder of the National Police Suicide Foundation, Inc. out of Seaford, Delaware. The Foundation provides educational training seminars for emergency responders on the issue of suicide / mental health. In July 1994, Bob retired as an Agent after serving 20 years with the Baltimore City Police Department and 5 years as a Patrol Officer with the Temple Terrace Police Department in Temple Terrace, Florida. He holds a B.S. Degree in Criminal Justice from the University of South Florida and a Masters of Science Degree in Criminal Justice Management from the University of Baltimore. Bob also has a Masters in Theology from St. Mary's Seminary and a Doctorate Degree in Christian Counseling from Kingsway University and Theological Seminary in Norwalk, Iowa. Bob lectures at the FBI National Academy on Mental Health / Suicide Prevention for Law Enforcement personnel. He recently retired as the Senior Pastor at Jenkins Memorial Church in

Riviera Beach, Maryland, where he has served for 24 years. Bob also served as Police Chaplain for FOP Lodge #3 in Baltimore City from 1988 to 2002 and served as Chaplain for Alcohol, Tobacco, and Firearms in Washington, D.C. Bob is also the founder of Compassionate Shepherd Ministries in Laurel, Delaware.

Additional Contributors

Ron Clark, RN, MS, APSO is a military veteran and a retired sergeant from the Connecticut State Police (CSP) with 23 years of law enforcement service. He was the first certified CSP Peer Helper and Instructor, commander of the EAP / Medical unit and was a member of the tactical team as an Advanced Life Support Medic. He was also the Senior Flight Nurse for the Med-Evac unit and coordinated the Surgeons and Chaplains program. He helped establish the first Critical Incident Stress Debriefing Team in Connecticut and served as its President. Clark holds a Master of Science degree in Counseling Education and has been a Registered Nurse since 1969. He served 12 years as the Chairperson of the Middlebury, CT, Police research and education collaborative dedicated to the health and well-being of law enforcement officers and the communities they serve.

William Evans is the Commissioner of the Boston Police Department. Evans was born in Boston and grew up in a crowded, triple-decker apartment. Evans was raised by his four older brothers after the death of his mother when he was three years old. In 1980, he was a Boston Police Cadet and joined the Boston Police Department in 1982. He spent five years as a patrolman, during which time he was awarded the BPD's Medal of Honor for his role in apprehending an armed robbery suspect following a high-speed chase. As a captain, Evans was first stationed in District 14, which consisted of the Allston-Brighton neighborhood of Boston. It was the BPD's most densely populated district and contained 75,000 residents. Evans continued

to move up the ranks throughout his years of service, and in 2009, Evans was promoted to Superintendent in charge of the Bureau of Field Services, overseeing special events and the Department's patrol division. Evans played a role in the peaceful handling of Boston's 70-day occupation of Dewey Square and had pivotal responsibilities in the Boston Marathon bombing strategic response team. On November 1, 2013, Mayor Menino appointed Evans Interim Commissioner of the Boston Police Department. In January 2014, Mayor Walsh invited Evans to serve as Police Commissioner on a permanent basis. Evans has made historic strides in diversity and inclusion by appointing the first black Superintendent-in-Chief, William Gross, and bolstering his command staff with a 40% representation of minorities and women.

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Executive Summary

Overview

The unparalleled bravery of first responders is brought to the attention of the public following huge and tragic events, such as the recent incidents of terror in Parkland, Las Vegas, Orlando, Sandy Hook, and more. However, public discourse seldom acknowledges the fact that first responders witness tragedy and horror regularly, if not daily. Constant exposure to death and destruction exerts a toll on the mental health of first responders, and yet many do not disclose mental health issues nor do they access treatment. This paper seeks to raise awareness about the issue of mental health among first responders in order to alleviate stigma and facilitate access to services.

Focus and Findings

This paper presents data on the prevalence of mental illness and suicide among first responders. Key take-aways are as follows:

- Police and firefighters, when compared to the general civilian population, are at heightened risk for depression, post-traumatic stress disorder (PTSD), and suicide.

These findings are also relevant for EMS workers, but since many EMS workers are also firefighters, these two professions are often undistinguished in research.

- Both police officers and firefighters are more likely to die by suicide than in the line of duty.
- At least 22 Massachusetts firefighters have taken their own lives since 1996, and 4 EMS workers have died by suicide since 1997. On average, there is one *reported* firefighter suicide per year in Massachusetts. The actual number is likely much higher. *We estimate*

that the suicide rate for firefighters in Massachusetts is twice as high as the suicide rate for the general Massachusetts population. This is the first paper to report state-specific data on first responder suicide for Massachusetts.

- The vast majority of first responder suicides are not covered by the mainstream media, and the public is not given the opportunity to celebrate the lives of those lost.
- There are several barriers that prevent first responders from accessing mental health services, including shame and stigma. These same barriers prevent families from talking openly about the suicide of a loved one, thereby contributing to silence and lack of awareness around the issue of first responder suicide.
- There are also several innovative approaches to promoting mental health among first responders, and many of them are currently at work in the city of Boston.

Conclusions

Leaders within the first responder professions are beginning to speak openly about mental health. Commissioner Evans of the Boston Police Department speaks openly about how he prioritizes his own mental health and the mental health of his officers. There is still a lot of work to be done to ensure that all first responders feel encouraged and not ashamed to access critical and potentially life-saving mental health services. Recommended next steps include exploring instituting *mandatory* mental health check-ups for first responders. Also, we should celebrate the lives of first responders who die by suicide. Through media coverage and more, they should be remembered as heroes.

Introduction

First responders witness horror on a daily basis. These men and women, including

firefighters, law enforcement personnel, and emergency medical services (EMS) workers, have front row seats to the horrendous aftermath of natural disasters, terrorist attacks, violent domestic disputes, traffic accidents, and more. [Many first responders have military experience](#), and therefore their experiences as first responders pile onto a career that is already rife with trauma. These professionals embody astounding bravery and resilience, but at the end of the day, they are only human. Constant exposure to death and destruction exerts a psychological toll on first responders, resulting in post-traumatic stress disorder (PTSD), substance abuse, depression, and even suicide. This paper brings to light the high rates of mental illness and suicide among first responders. It is critical to address this issue in order to destigmatize mental illness so that our heroes are able and comfortable to access the care that they need. Their lives depend on it.

In the aftermath of “big events”, news outlets illuminate the heroism of first responders. In the days and years following the [September 11th attacks on the World Trade Center](#), [the 2017 terror attack in Las Vegas](#), [and the recent wildfires in California](#), the American public learned of the rescuers who sacrificed their health and well-being in order to save others. This recognition is well-deserved and important; the public should know about and celebrate the men and women who ran towards the collapsing buildings, bullets, and wildfires so that they might have a chance to save a life. However, often missing from these portraits of heroism is the acknowledgement that *first responders are exposed to trauma on a daily basis*. Law enforcement personnel use the term *critical incidents* to describe traumatic events, examples of which are listed in Table 1. In one [survey](#) of 193 police officers from small and midsize police departments, officers reported the number of critical events that they had witnessed during the course of their career. The average number of events witnessed by officers was 188 (Chopko, Palmieri, and Adams, 2015). Also, the officers had witnessed a wide variety of horror; on average, the events that they witnessed fell into 15 different categories (the categories are listed in Table 1 below). Several

academic studies have documented trauma and its consequences among first responders. These studies provide an important base of information, but they are not widely disseminated outside of academic circles and therefore do not by themselves raise public awareness about the critical issue of mental health. In one [study](#) of 400 police officers, 10% of those surveyed reported that they had killed or seriously injured someone during the first three years of their career (Komarovskaya et al., 2011). Clearly, traumatic experience is not restricted to the big news events that the American public sees on television.

Table 1: Critical Incidents in the Law Enforcement Profession (taken from [Chopko et al., 2015](#))

Mistake that injures / kills colleague Mistake that injures / kills bystander Colleague killed intentionally Colleague killed accidentally Being taken hostage Being seriously beaten Being shot at Colleague injured intentionally Kill or injure in the line of duty Badly beaten child Sexually assaulted child Trapped in life-threatening situation Severely neglected child Threatened with a gun Your loved ones threatened Seriously injured intentionally Life-threatening man-made disaster Exposed to AIDS or other diseases Colleague injured accidentally Shoot at suspect without injury Threatened with knife / other weapon Mutilated body or human remains Life-threatening natural disaster Life threatened by toxic substance See someone dying Making a death notification Being seriously injured accidentally Life-threatening high speed chase Sexually assaulted adult Animal neglected, tortured, killed Decaying corpse Life threatened by dangerous animal Body of someone recently dead Badly beaten adult

It is not surprising that exposure to trauma is linked to mental health issues, including PTSD and substance abuse. In one [study](#) of 750 police officers, researchers found that exposure to critical incidents was statistically significantly correlated with alcohol use and PTSD symptoms (Menard & Arter, 2013). Officers who had experienced more critical incidents were more likely than their colleagues who had experienced fewer such incidents to report experiencing PTSD symptoms and using alcohol.

It is clear that first responders experience trauma as they respond to events that do not necessarily make national news, and yet the mainstream media is only beginning to talk about the intersection between mental illness and the lived experiences of firefighters and law enforcement officers. Relevant headlines include, “[Increasing First Responder Suicide Rates Spark Concern](#)” (US News and World Report), “[Firefighter Raising Awareness about Risk of Depression, Suicide, For First Responders](#)” (NBC Washington), and “[A Quiet Rise in Wildland Firefighter Suicides](#)” (The Atlantic). As this paper will demonstrate, given the prevalence of mental illness and suicide among first responders, the media must pay more attention to this issue. This will be a critical step towards destigmatizing the receipt of mental health services for those who need it most, the bravest among us who put their lives in danger daily in order to protect us all.

Prevalence of Mental Illness

Dozens of articles have been published in research journals which document prevalence rates of mental health issues among various groups of first responders. These articles are important because they document the mental health crises that impact first responders. As this paper argues, a critical next step will be to bring this issue to the forefront of public attention.

This section begins with a review of the prevalence rates of issues including alcohol abuse, depression, suicidal ideation, and PTSD. Firefighters and law enforcement officers are discussed in turn, and this information is summarized in Table 2. Trauma and mental health are also relevant for EMS workers, but since a vast number of these individuals are also firefighters, most research does not distinguish between the two ([Stanley, Hom, & Joiner, 2016](#)). Therefore, the discussion of firefighters is applicable to EMS workers as well.

The major takeaway from the academic research is that multiple forms of mental illness are more common among first responders than among civilians. Suicide is among the most devastating consequences of mental illness, and numerous studies have documented the extent to which mental illness (including alcohol abuse, depression, and PTSD) is a risk factor for suicide among first responders. These issues are described below, and are followed in the next section by a discussion of the toll of mental illness – including diminished work capacity and most tragically, suicide.

<i>Mental health outcome</i>	<i>Fire fighters</i>	<i>Police officers</i>	<i>General population</i>
PTSD	14.6% - 22% ¹	35% ²	6.8% (in one's lifetime) ³
Depression	11% ⁴	9% ⁵ - 31% ⁶	6.7% ⁷
Thoughts about suicide	46.8% (ever)	7.8% (pervasive)	unknown

¹ [Martin, Vujanovic, Paulus, Bartlett, Gallagher, & Tran, 2017](#)

² [Austin-Ketch, Violanti, Fekedulegn, Andrew, Burchfield, & Hartley, 2012](#)

³ [United States Department of Veterans Affairs, 2017](#)

⁴ [Carey, Al-Zaiti, Dean, Sessanna, & Finnell, 2011](#)

⁵ Robert Douglas, personal communication

⁶ [Obidoa, Reeves, Warren, Reisine, & Cherniack, 2011](#)

⁷ [National Institute of Mental Health, 2017](#)

Firefighters

According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5), PTSD is a condition that results from exposure to "death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence" (American Psychiatric Association, 2013). The person who suffers from PTSD "persistently" re-experiences the event in forms such as flashbacks and nightmares, and general well-being is impacted through symptoms that include trouble sleeping, trouble concentrating, irritability, and feelings of isolation, self-blame, and more (American Psychiatric Association, 2013). Several studies have documented high rates of PTSD among firefighters. In one [study](#), researchers administered a standardized measure of PTSD called the Impact of Events Scale – Revised to 94 paid professional firefighters, and they gave the same assessment to 91 professionals from occupations outside of emergency service (Wagner, McFee, & Martin, 2010). The firefighters scored statistically significantly higher than the group of other professionals on the measure of PTSD; in fact, their scores were approximately twice as high. It is important to note that there is diversity within the firefighter community, and firefighters from different backgrounds might be more or less susceptible to PTSD. For example, some geographic locations have easily available mental health services, while it might be more difficult to access these services in relatively remote areas. Also, different attitudes towards mental health exist across cultures (i.e., Hispanic versus Caucasian), and this impacts the likelihood that firefighters will seek mental health treatment. Finally, paid firefighters might be more likely to receive mental health services through their departments than their volunteer counter parts. While these differences are important, the several studies that have investigated PTSD among firefighters have each concluded that the rate of PTSD is higher for firefighters than for civilians, regardless of

geographic region (urban versus rural), ethnicity, and paid versus volunteer status ([Arbona & Schwartz, 2016](#); [O'Neill & Wagner, 2012](#); [Wagner et al., 2010](#)). Clearly, PTSD is a pervasive challenge among the men and women who risk their lives to save the lives of others.

In addition to documenting the prevalence of PTSD among firefighters, researchers have also noted high rates of binge and hazardous drinking behavior. One research team examined drinking among female firefighters, and found that 40% reported binge drinking during the previous month, and 16.5% of female firefighters who used alcohol screened positive for problem drinking behaviors ([Haddock, Poston, Walker, Jahnke, & Jitnarin, 2017](#)). Another [study](#) included both male and female firefighters and found even higher rates of binge and hazardous drinking – 58% and 14%, respectively (Carey, Al-Zaiti, Dean, Sessanna, & Finnell, 2011). These same researchers found a depression rate of 11% in their sample of 112 firefighters, compared to 6.7% in the general United States population of adults ages 18 and over. The consequences of depression, substance abuse and PTSD are severe; in a survey of more than one thousand fire fighters from across the country, 46.8% reported thinking about or imagining suicide at least one time during their career ([Stanley, Hom, Hagan, & Joiner, 2015](#)). Statistics on completed suicides are presented later in this paper.

Taken together, this research documents the prevalence of mental illness among firefighters. As subsequent sections demonstrate, mental illness exerts a huge toll, with consequences including diminished work performance and even suicide. These studies also demonstrate that within the academic and research circles, people are paying attention to the issue of firefighter mental health. A common theme throughout this paper is that the time is now to expand this conversation to the larger community. This will help erase the stigma around

mental health, so that our heroes feel comfortable accessing the help that they so desperately need.

Law enforcement officers

Police officers respond to different calls than firefighters, but across these two professions, we see a similar impact of trauma on mental health. We saw previously that there is diversity among firefighters, and there is diversity among law enforcement personnel as well. These professionals come from different cultural backgrounds, they have different personal histories, and they occupy a wide array of roles in law enforcement. Each of these factors and many more impact how people respond to traumatic events, what services they can access, and how they feel about accessing these services. Despite this diversity, we see a pattern of poor mental health outcomes among our heroes in blue. In one [survey](#) of 220 corrections officers, researchers identified a depression rate as high as 31% (Obidoa, Reeves, Warren, Reisine, & Cherniack, 2011). This figure is astounding in light of the [6.7% prevalence rate](#) in the general population (National Institute of Mental Health, 2017). Other studies of law enforcement officers have obtained smaller estimates of depression prevalence (9% in a sample of police officers), but even with this smaller estimate, the prevalence of depression is higher within this profession than within the civilian population (Robert Douglas, personal communication).

Our police officers deal with other mental health issues as well. [One team of researchers](#) estimated the prevalence of PTSD to be 35% (Austin-Ketch, Violanti, Fekedulegn, Andrew, Burchfield, & Hartley, 2012). These processes have disastrous consequences; in one [survey](#) of 193 active police officers in a Midwestern state, 7.8% agreed with the statement, “found the idea of taking your own life kept coming into your mind” (Chopko, Palmieri, & Facemire, 2014).

As we saw with firefighters, considerable effort within the academic and research communities has been made to identify and document mental illness among law enforcement personnel. This epidemic of mental illness among first responders has disastrous consequences for the men and women in uniform, and for all members of society. This paper will turn to a discussion of these consequences, which range from diminished daily functioning to suicide. The paper will then highlight barriers to care, as well as a discussion of promising practices in the arena of first responder mental health, with a focus on Boston.

The Toll of Mental Illness

Mental Illness in the Daily Life of First Responders

Depression, PTSD, and substance abuse cause suffering for individuals with these conditions and their family members. This human suffering is sufficient justification to pay attention to the widespread prevalence of mental illness among the first responder community. In addition to the impact on individuals, the cost to society of ignoring these issues is high; we know that mental illness is treatable, and yet without treatment, it can severely impact and limit functioning. Our society depends on the intuition, energy, and decision-making skills of first responders, and untreated mental illness exerts a toll on these capacities. One [study](#) conducted by researchers at the University of Toronto demonstrates how dangerous it is to ignore the mental health crises among our first responders. Researchers interviewed emergency workers from several different professions, including police officers, police communicators, paramedics, and child protection workers. They assessed the extent to which each study participant had PTSD, and they also exposed study participants to simulated emergencies in the research laboratory. They found that first responders with PTSD showed “performance deficits on complex cognitive tasks”, which could include tasks that required first responders to assess risks,

plan multi-step responses to an emergency, and pay attention to competing stimuli (i.e., more than one victim and / or perpetrator) (Regehr & LeBlanc, 2017). This research finding makes perfect intuitive sense; symptoms of PTSD include flashbacks and intrusive thoughts, and when people are distracted, they are less able to devote attention to the task at-hand. We frequently hear about the impact of distracted drivers – drivers who are texting are dangerous behind the wheel, for example. Distraction in the form of PTSD is no less dangerous when it impacts the decision making of first responders. One [study](#) found that within a sample of more than 3,000 firefighters, those who had PTSD symptoms were more likely to report having work-related injuries, compared to their colleagues who did not have PTSD (Katsavouni, Bebetos, Malliou, & Beneka, 2016). And yet all too often, we ignore the PTSD, fail to provide adequate treatment, and contribute to the diminished capacity of our first responders. In an article that appeared in the FBI's [National Academy Associate Magazine](#), one police officer shared, “When I was involved in my first shooting, I was cleared right away and I wasn’t given any administrative time off. Basically they bought you a beer and told you you were a hero. You had to deal with it all on your own, and there weren’t any department resources, not even a chaplain to talk to.”

Mental health can be deleterious to physical health, and poor physical health interferes with first responders’ abilities to complete their daily work. Therefore, the relationship between mental health and physical health is another piece of evidence that ignoring the mental health of first responders is costly to our society. All humans exert stress hormones such as cortisol, and moderate levels of these hormones are normal and healthy. However, when levels of stress become toxic and hormone levels increase, this exerts a physiological toll on the body. Heightened levels of cortisol disrupt functioning of the immune and metabolic systems, for example. Given the high rates of mental illness among first responders, we would expect to see

heightened rates of poor physical health outcomes as well, and there is research to support this hypothesis. In one [study](#) conducted by researchers at the Centers for Disease Control and Prevention, researchers compared several health indicators between a cohort of police officers and the general American population. The study found that “a higher percentage of officers were obese (40.5% vs. 32.1%), had a metabolic syndrome (26.7% vs. 18.7%), and had higher mean serum total cholesterol levels (200.8 mg/dL vs. 193.2 mg/dL) than the comparison employed populations (Hartley, Burchfiel, Fekedulegn, Andrew, & Violanti, 2011). Physical health is an essential prerequisite for a productive and reliable workforce. With physical health so dependent on mental health, we are doing ourselves a disservice by ignoring the mental health crisis among first responders.

Suicide

Suicide is the most catastrophic consequence of failing to treat mental illness. PTSD, depression, and alcohol abuse are often present before a suicide, and therefore we should view these disabilities as opportunities to provide treatment that could potentially save lives. In one [study](#) of firefighters, researchers found that elevated levels of PTSD were associated with a higher likelihood of thinking about suicide and / or having a history of suicide attempts (Boffa, Stanley, Hom, Norr, Joiner, & Schmidt, 2017). [Other researchers](#) reached a similar conclusion about the relationship between depression and thinking about suicide; firefighters who reported experiencing depression were more likely than their non-depressed colleagues to think about suicide (Martin, Tran, & Buser, 2017). Substance abuse also plays a critical role in suicide; alcohol is present in over 85% of police officer suicides (Robert Douglas, personal communication).

Suicide is the tragic result of mental illness that so often goes untreated and / or ignored. *This paper is the first to present suicide rates across several categories of first responders. As such, it should be a critical call to action for all who care about our heroes in red and blue.*

Data regarding suicide rates of firefighters and police officers is described below, and compared to suicide rates among the general civilian population. Table 3 below provides a summary of the statistics on suicide.

Table 3: Suicide Rates			
	<i>Firefighters</i>	<i>Police officers</i>	<i>General population</i>
Suicide rate	18 / 100,000 ⁸	11-17 / 100,000 ⁸	13 / 100,000 ⁸

Note. Suicide prevalence rates for police officers come from the Badge of Life. Suicide data for firefighters was provided by the FBHA, and prevalence rates were calculated as described below. Please see the methodology section for more information.

In 2017, at least 103 firefighters and / or EMS workers across the United States committed suicide. Data for firefighters and EMS workers is combined, since many professionals play both roles. In the paragraphs that follow, to avoid confusion, this group will be referred to as firefighters.

The 103 firefighter deaths represent a decrease from previous years; there were 143 and 139 reported suicides in 2015 and 2016, respectively. In contrast, there were 93 firefighters who died in the line of duty in 2017. *Firefighters are more likely to die by suicide than in the line of duty.* Data on firefighter suicide comes from the [Firefighter Behavioral Health Alliance](#) (FBHA), an organization that receives confidential reports on firefighter suicide through its website. For each reported suicide, the Founder of FBHA contacts the Chief of the deceased’s fire department to validate the report. While FBHA is well-known among firefighters, many

firefighters have not heard of the organization and therefore the number of reported suicides is an undercount of the actual number of suicides. FBHA estimates that approximately 40% of firefighter suicides are reported. If this estimate is correct, *the actual number of 2017 suicides would be approximately equal to 257. This is more than twice the number of firefighters who died in the line of duty.* This estimate of 257 was divided by the total number of [career and volunteer](#) firefighters in the country plus the total number of [EMS workers](#) in the country, to arrive at the prevalence rate listed above in Table 3, which is strikingly higher than the prevalence rate for the general population.

The suicide rate among police officers is also shockingly high. An organization called [Badge of Life](#) is conducting ongoing web surveillance to capture police suicide data. According to a [publication](#) by the organization, “In this age of world web communications, a police suicide in even the smallest and most remote community is generally transmitted nationally and through police websites, forums, and blogs” (O’Hara, Violanti, Levenson, & Clark, 2013). As many as 55,000 websites are reviewed each year by organization staff. This review has identified 141 suicides in 2008, 143 suicides in 2009, 126 suicides in 2012, 108 suicides in 2016, and 140 suicides in 2017 (the years for which data is available). Numbers of police officer suicide deaths and line of duty deaths fluctuate annually, but in 2017 there were [129 line of duty deaths](#), in contrast to 140 suicides. In 2012, Ronald Davis, the Director of the Office of Community Oriented Policing Services (COPS) announced that the number of police officer deaths from suicide that year was “twice as high as compared to traffic accidents and felonious assaults during 2012” ([IACP](#), 2014). *As is the case with firefighters, in 2017, police officers were more likely to die by suicide than in the line of duty.*

Regarding the comparison between national police officer suicide rates and national

civilian suicide rates, according to statistics collected by the [Badge of Life](#), police officer suicide rates fluctuate around the suicide rates of the general population, and in some years the rate of police officer suicide is considerably higher than the rate of civilian suicide. In 2008, the police officer suicide rate was 17/100,000, compared to a general rate of 11/100,000. This discrepancy has declined recently; in 2016 there were 12 police officer suicides per every 100,000 officers, compared to 13 civilian suicides per every 100,000 civilians. This lower rate of police officer suicides compared to civilian suicides might be unique to 2016; in 2016 there were 108 police officer suicides, and in 2017 there were 140 (a 30% increase).

Also, according to Ron Clark of the Badge of Life, the suicide rate for police officers should be even lower than the suicide rate among the civilian population. This is because police officers must pass psychological assessments before they are allowed entry into the law enforcement profession. Therefore, at entry into the field of law enforcement, *all police officers meet a baseline of mental health*. The suicides we see must reflect deterioration of mental health that occurs after men and women become police officers.

This issue is not adequately addressed through policy or practice. In the words of Craig Steckler, the President of the International Association of Chiefs of Police, “Officer mental health is an issue of officer safety, and we should treat it as such. From body armor and seatbelt use policies, to self-defense and verbal judo training, we can all list a variety of measures available to ensure our officers’ physical safety. But what are we doing to actively protect and promote their mental and emotional health? Sadly, in many cases, it is not enough” ([IACP](#), 2014).

Unfortunately Massachusetts is not immune to the catastrophe of first responder suicide, and this is the first publication to bring this startling fact to light. Data for Massachusetts is separated for firefighters versus EMS professionals. In Massachusetts, at least 22 firefighters

have died by suicide since the year 1996, averaging about one death each year. Numbers from recent years indicate that there might be an increase in the prevalence of firefighter suicide in Massachusetts. There were three reported deaths in 2013, 5 in 2014, 2 in 2015, 2 in 2016, and in 2017, at least two firefighters died by suicide. While these numbers from recent years are higher than the one death per year average noted above, it is also possible that we are seeing a rise in reporting, and not a rise in actual death by suicide.

If we use the most recent year for which data is available, 2017, then the two *reported* firefighter deaths that year yield a suicide prevalence rate of 8.3/100,000, with an estimated total of 24,000 firefighters in Massachusetts, according to the State Fire Marshall’s office (Jeff Dill, personal communication). If we assume that those two deaths represent 40% of the actual number of firefighter deaths by suicide, then the prevalence rate grows to 20.8/100,000. This is in contrast to the overall suicide prevalence rate of [9/100,000](#) in Massachusetts. At a bare minimum, firefighters commit suicide at the same rate as others in Massachusetts. If we assume that the number of reported suicides is lower than the number of actual suicides (which is by all means a fair assumption), *we can arrive at the hypothesis that firefighters commit suicide at more than twice the rate of other residents of Massachusetts.*

At least four emergency medical services workers living and working in Massachusetts have taken their own lives since 2007. State-specific data on police officer suicide is not available, but there is no reason to believe that police officers in Massachusetts are immune to the mental health crises that impact their colleagues across the country. See Table 4.

Table 4: Massachusetts Suicides	
<i>Firefighters (since 1996)</i>	<i>EMS workers (since 2007)</i>

Suicides in Massachusetts	22	4
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Note. Suicide information comes from the FBHA. Please see the methodology section for more information.

There are a couple of caveats that need to be presented alongside this data. First, while comparisons to the general civilian population can be instructive, they should be interpreted with caution. Suicides in the general civilian population are more common among males than females ([National Institute of Mental Health](#), 2017), and the majority of both firefighters and police officers are male. The second caveat is as follows. Experts in the field unanimously agree that the reported suicides reflected in the numbers above are a vast underestimation. Shame prevents family members from disclosing the suicide of loved ones. As noted previously, experts estimate that the data on firefighters cited above only represents 40% of actual firefighter suicides. There is underreporting of police officer suicides as well. Shame and stigma breed incentives for hiding the suicide of a loved one; in some police departments, officers who die by suicide are not buried with honor, and the names of officers who die by suicide are not permitted on the National Law Enforcement Memorial in DC. Departments are also wary to acknowledge death by suicide; the President of the International Association of Chiefs of Police has referenced “collective silence” and a “refusal to speak openly about the issue” of mental health and suicide ([IACP](#), 2014). As a result of shame and stigma surrounding suicide experts, estimate that “approximately 17% of police suicides are misclassified as accidents or undetermined deaths” ([O’Hara et al.](#), 2013).

This paper will now turn to a discussion of the barriers that impede progress around the issues of first responders, mental health, and suicide. It will conclude with promising practices – programs and policies across the nation and in our local Boston community that have accepted the call to better serve our nation’s heroes.

Barriers to Progress

The issue of first responder suicide is complex and difficult to address. Approximately 90% of police officers who commit suicide use a gun, and it is not possible to limit police officer access to these weapons (Robert Douglas, personal communication). There are also cultural barriers – personality traits that exist within the men and women who become first responders in the first place, cultures within the professions and the departments, and lack of awareness across the American public about mental health in general. In addition to these cultural barriers, policies within departments make it difficult for first responders to access the critical and life-saving mental health care that they need. Accessibility and affordability of services are examples of these policies that, for better or for worse, can impact mental health outcomes. This section explores cultural barriers and policy impediments to promoting positive mental health among first responders. The white paper then concludes with a look at promising practices – a window into policies and programs in Massachusetts and beyond that are pushing the needle on first responder mental health.

Cultural Barriers Among First Responders

The men and women who choose to become first responders, the people who make a career out of risking their lives to help others, see themselves as tough. Experts describe first responders as “macho” and having a “lack of empathy” for mental health issues ([Bell & Eski, 2016](#)). The President of the International Association of Chiefs of Police has said, “In a profession where strength, bravery, and resilience are revered, mental health issues and the threats of officer suicide are often ‘dirty little secrets’ – topics that very few want to address or acknowledge” ([IACP, 2014](#)). In fact, not only are people embarrassed to speak openly about their struggles with mental health, they fear that speaking out could negatively impact their career advancement. There is the perception that honesty around mental illness could be “career

destroying” (Bell & Eski, 2016). This perception is not unjustified; as described previously, young men and women who wish to become police officers must pass a mandatory psychological screening. To some extent, mental health is a prerequisite for this work.

In this climate in which no one talks about mental health, first responders feel isolated and do not access the help that they so desperately need. Ron Clark, Chairman of Badge of Life, says that countless officers who have struggled with mental health issues have said to him, “I feel like an orphan in my own department” (Ron Clark, personal communication). The irony is that first responders *perceive* their colleagues to be judgmental about mental health issues, but this perception might not accurately reflect reality. In one [study](#) of 248 police officers, officers shared their own perceptions of mental illness, and they also shared how they think their colleagues perceived mental illness. The police officers indicated that their colleagues were unaccepting of mental illness, and yet those same colleagues were less judgmental than their colleagues assumed them to be (Karaffa & Koch, 2016). One can infer from these results that officers do not talk about mental illness with their colleagues, and silence is interpreted as negative judgment. From this same survey, researchers found that officers who assumed their colleagues were judgmental about mental health issues were less likely than other officers to access mental health services for themselves.

Given the lack of conversation around mental health amongst first responders, it is perhaps not surprising that conversation around suicide is also sparse. The majority of police departments do not have a policy related to police officer suicide within their organization (Robert Douglas, personal communication). Of the 18,000 law enforcement agencies across our nation, approximately 3-5% have suicide prevention training programs (Robert Douglas, personal communication). Clearly, departments are reluctant to openly address this issue, although there are exceptions, which are discussed later in this paper. In departments in which

silence prevails, officers and firefighters who are contemplating suicide do not know that they are not alone. They do not know that there are people out there who can help them, and that they must not be ashamed to ask for help.

In summary, there is not enough conversation about mental health within police and fire departments. Silence can be deadly, because it is interpreted as a lack of acceptance and thus morphs into a barrier that prevents first responders from accessing potentially life-saving mental health services.

Lack of Awareness Within the Larger American Public

Stigma around mental illness is not isolated within fire, police, and EMS departments. According to the [National Alliance on Mental Illness](#), on average, children and teens with mental illness wait eight to ten years after the onset of symptoms to access mental health services. This can be attributed to many factors, including people's lack of knowledge about their own condition, an unwillingness to self-identify as a person in need of mental health services, shame, fear, embarrassment, and lack of availability of services. All of these factors relate to stigma. If young children were educated about mental health, if policy makers prioritized and funded mental health services to the same extent as other medical services, and if people spoke openly about mental illness so as to eradicate shame – if all of these elements of stigma were erased from our society – people would no longer wait ten years before accessing services. This would diminish suffering and also enable people to fulfill their potential; research cited earlier in this paper found that the experience of mental illness can interfere with decision making, a skill that is critical for our first responders that devise emergency responses on a daily basis. Raising public attention around mental illness will lead to all people accessing services more quickly after the onset of symptoms, and our first responders are included among the people who will

benefit. This will reduce the number of suicides, and also enable our first responders to fulfill their duties to the best of their abilities.

Yet despite the imperative of having a society that acknowledges mental illness and the importance of mental health services, major media outlets stay relatively silent around this issue as it pertains to first responders. As described in an earlier section of this paper, firefighters are more likely to die by suicide than in the line of duty. Similarly, about twice as many police officers die by suicide than are killed by gunshot or in a traffic accident, combined. And yet from reading the news or watching it on television, one would never guess this. An online search of the New York Times revealed *no articles about police officer or firefighter suicide in 2017*. The lead author of this paper entered the search terms “police officer suicide” and restricted the dates to search for articles published between January 1st 2017 and January 29th 2017. *Zero relevant articles appeared*. Then, the lead author entered the terms “firefighter suicide”, and restricted the dates to the same range. The New York Times published no articles about firefighter death by suicide during this time period. There are older articles about first responder suicide, such as an article published in 2003 entitled [Officer Shoots Himself](#). However, since we know that there are dozens of first responder suicides every year, it is still fair to conclude that the mainstream media outlets stay relatively silent on this issue. In contrast, media outlets provide extensive coverage of first responders who are killed in the line of duty. New York Times headlines from the most recent twelve months include, [Officials Piece Together Chaotic Events After Officer Killed](#), and [A Risk We Choose: Emergency Workers Mourn One of Their Own](#), and [The Latest: Suspect in Deputy’s Death Appears in Court](#). This coverage is appropriate, since these men and women are heroes who should be publicly acknowledged and mourned. Yet stories about first responder suicides are rare, likely feeding a public impression that this is not an issue. The public needs to know about this as an issue, so

that our citizens can push policy makers to devote funds, and so that our first responders can feel supported instead of ashamed as they make the brave decision to access services.

The Boston Globe has published pieces related to first responder mental health, most notably a piece in 2016 entitled [True Crime: The toll of duty](#). This piece was an important first step, and yet it did not provide data regarding the prevalence of suicide in Massachusetts. Also, in a search of Boston Globe articles conducted in the same manner as the New York Times search (described above), only four articles were found (in an unlimited date range) that covered the suicide of a first responder. We know that suicides in Massachusetts occur annually for firefighters alone, and more than annually when police officers are taken into account; they should be brought into the public light in order to reduce stigma and facilitate access to care.

Pragmatic Barriers

Shame and stigma are arguably the strongest barriers that stand between first responders and mental health services. However, it is important to acknowledge pragmatic barriers as well, including the convenience of accessing services, work schedules that permit mental health treatment, etc. Surveys of both police officers and firefighters have revealed that these pragmatic barriers are pervasive. In one online survey administered to 525 firefighters from across the United States, firefighters reported on the cost and availability of mental health services ([Stanley, Boffa, Hom, Kimbrel, & Joiner, 2017](#)). The responses from these firefighters suggest that access to services is particularly problematic for volunteer firefighters, and as a result, this particular group of first responders has worse mental health outcomes than career first responders. Police officers, especially those who work for small police departments (not large urban centers), also report pragmatic barriers to service access ([Violanti, Hartley, Mnatsakanova, Andrew, & Burchflel, 2012](#)). When the American public pays attention to issues surrounding the mental

health of first responders, decision makers will feel pressure to remove these pragmatic barriers. Raising awareness about these issues is a critical step in the right direction.

Steps in the Right Direction

Legislative Action

In January of 2018, President Trump signed into law the [Law Enforcement Mental Health and Wellness Act](#). This law provides funding for peer mentoring programs, designed to enable law enforcement officers to get help from those who truly understand their experiences – their law enforcement colleagues. The law also calls for an evaluation of the effectiveness of other initiatives, including crisis hotlines and mandatory mental health wellness checks. This is a critical step in the right direction, as it explicitly addresses pragmatic barriers by providing funds for services.

First Responder Leadership

Several first responders have called for greater attention to the issue. Jeff Dill, a retired firefighter, founded the [Firefighter Behavioral Health Alliance](#) (FBHA) in 2011, and the organization is dedicated to raising the profile of issues surrounding mental health, and challenges related to on-the-job trauma and the stressors of retiring. FBHA staff travel over 130,000 air miles every year presenting workshops on subjects including addictions, PTSD, depression, suicide, retirement, and developing programs for families. FBHA also does consulting work for organizations who want to develop or enhance their own behavioral health programs. FBHA was recently hired by the San Diego Fire Department to assist in developing their program.

The [National Police Suicide Foundation](#) (NPSF) is a comparable organization devoted to

addressing this issue as it pertains to law enforcement officers. NPSF provides educational seminars to educate the general public along with law enforcement organizations on suicide awareness and prevention. The organization also provides scholarships for family members nationwide who lost loved ones to law enforcement suicide. The mission of NPSF is to provide suicide awareness and prevention training programs and support services that will establish a standard of care for emergency responders and promote employee wellness.

Police leadership is paying attention. The President of the International Association of Chiefs of Police has declared that “officer mental health is an issue of officer safety” ([IACP](#), 2014). In 2014, the International Association of Chiefs of Police (IACP) issued a report entitled [Breaking the Silence of Law Enforcement Suicides](#). This report contains suggestions for specific programs and policies that departments can adopt in order to push the needle on this issue. For example, peer support and employee assistance programs should ensure that first responders receive care from others who understand their unique experiences – other first responders. Family training programs alert family members to the warning signs of depression, PTSD, substance abuse, and suicide, so that families can look out for their loved ones and refer them to care if needed. Some departments encourage annual mental health check-ups. The report also provides sample policies and procedures for departments to follow after an officer experiences a critical incident. These policies may include mandatory mental health services, or time off to facilitate access to mental health services. Finally, the report suggests recommendations for ways in which a department can honor the life of an officer who died by suicide. Hopefully, respectful celebrations of life will reduce much of the shame that family members experience following these tragic events.

Perhaps most importantly, the 2014 report calls for culture change. It reads,

“Unfortunately, in many law enforcement departments the culture toward mental wellness or addressing emotional problems of any kind is one of disdain and avoidance. The presumption within this culture is often that the mere presence of an emotional problem indicates a weakness on the officer’s part. That perception leads to the even more dangerous perception that being open about these issues can make the officer vulnerable, even to the point of losing his or her job. Significant progress in curbing officer suicide and enhancing officer mental wellness is only achievable if the culture does an about-turn toward openness and support for all aspects of officer health and wellness, particularly mental health.”

Indeed, culture change is necessary in order for our first responders to feel encouraged and not ashamed to access the care that they need. In order to achieve culture change, first responder leadership must be vocal. The 2014 IACP report explains, “Hearing from the chief personally and candidly carries a tremendous amount of weight. In particular, police chiefs or others who have triumphed over their own mental health issues should champion this subject and share their own success stories.” This paper now sheds light on how Boston leadership is championing the issue of first responder mental health. Boston is lucky to have leaders who acknowledge the issue and are working towards enormous change.

Boston

The Boston Police Department

Since 2013, Commissioner William Evans has led the Boston Police Department. Commissioner Evans was interviewed for this white paper, and during this interview, he conveyed a strong commitment to the mental health of his officers. Commissioner Evans encourages his officers to seek mental health treatment by speaking about his own experiences. He talks openly about the stress, trauma, and exhaustion that he experienced in the aftermath of the Boston Marathon Bombing, during which he led the mission that ultimately led to the arrest of Dzhokhar Tsarnaev. After the arrest, Commissioner Evans’ wife encouraged him to seek counseling. He says, “It’s one of the best things she ever did, make me go talk to someone. I did it. It was good. Now I like to tell that story to people.”

And Evans does tell this story to people – he recently visited officers in the United Kingdom to discuss mental health in the aftermath of the shooting at the Ariana Grande concert. Evans, along with several other Boston Police Officers, have met with officers in the United Kingdom to express solidarity and to help erase stigma associated with the after-shocks of terrorism- depression, PTSD, anxiety, and more. Evans also visits trainees in the academy, and expresses to them the importance of health, both physical and mental.

According to Evans, the Boston Marathon bombing was pivotal in changing attitudes about mental health amongst Boston police officers. He recalls a time in which officers were supposed to be “tough guys” in the aftermath of tragedy, without any time off or encouragement to seek counseling. Now, after a critical incident, an officer is encouraged to access the Department’s array of mental health services, and paid time off can be provided. The Boston Police Department has a residential campus for mental health services where officers can stay for up to one week, and visits are completely anonymous. The Boston Police Department also has a partnership with McLean Hospital, which in the aftermath of the Marathon Bombing, agreed to provide psychological services to police officers at very low cost. Officers also have access to a premiere athletic facility, their family members receive education and support regarding mental health issues, and they benefit from the fundraising and programming of the Boston Police Foundation, an organization that is committed to promoting mental health and wellness. And as stated earlier, in Commissioner Evans, Boston police officers have a leader who sees the value in promoting mental health awareness.

When asked what he wishes he could accomplish in the realm of mental health, Commissioner Evans explained that mental health checks and services following critical incidents are voluntary and not mandatory. He wishes he could automatically provide paid time off and care to all officers who witness a tragedy. This is a clear and relevant vision for the

future. His mere articulation of this vision is a step in the right direction for first responders across the country, as it explicitly acknowledges the importance of mental health.

The Boston Fire Department

Patrick Hayes is a Lieutenant of the Boston Fire Department and the Employee Assistance Program Coordinator. This program enables firefighters to discuss mental health and related issues with their peers and colleagues – other firefighters. It also provides additional services, including referrals to treatment programs at places including McLean Hospital.

Lieutenant Hayes acknowledges the need to provide firefighters with mental health services, and he is also well aware that these services are more effective when they are peer-to-peer. He explained, “A cop isn’t going to want to talk to me. You generally gravitate towards your own people. The Peer Support Model is important. There are no civilians.” According to Lieutenant Hayes, this program is an asset to Boston. It has existed here since the 1980s, and many fire departments across the country don’t have similar programs, or any programs that utilize a peer support model.

Lieutenant Hayes agrees with Commissioner Evans that the Boston Marathon Bombing was a turning point with regard to how the city confronts mental health among first responders. After the bombing, firefighters became able to receive administrative leave with pay for absences related to mental health. Similar to the police department, the fire department formed a partnership with McLean Hospital following the bombing, enabling firefighters to receive services there through their insurance. With regard to the influence that the Marathon Bombing had on the fire department’s awareness of mental health, Lieutenant Hayes said that after this horrific event, he and several of his colleagues began to “see the light”. In many ways, our city responded to tragedy by becoming stronger, more aware, and building resilience through

facilitating access to mental health services.

As is the case across the country, there still do exist pragmatic barriers to care for firefighters in Boston. Lieutenant Hayes explained that many people must go out of state for substance abuse treatment, in order to go to a facility that aligns with their insurance coverage. Lieutenant Hayes believes that if more people could access care within Massachusetts, more people would get care overall.

The Boston Medical Community

Boston is known for its excellence in medicine, and the medical community here has taken on the issue of first responder mental health. The community has also extended the issue to consider the impact of trauma on all hospital professionals. Dr. Brendel, a psychiatrist at Massachusetts General Hospital, expressed during an interview that given the vast exposure to trauma among first responders and hospital employees, mental health issues should be expected, and therefore should not be referred to as “disorders” at all. Instead, we should speak of mental illness as an “occupational hazard” – a normal part of the job experience for both first responders and hospital employees.

Even before the Marathon Bombing, Boston was a recognized leader in the area. In 2008, Boston hosted a meeting supported by the CDC for international leaders from first responder and medical professions. The purpose was to discuss how to prepare for emergencies, and this preparation included addressing first responder mental health. Each participating hospital made changes based on the findings from the convening. At Massachusetts General Hospital, they implemented a system in which three mental health teams responded to each emergency: one team to help survivors directly, one team to help family members of victims, and a third team dedicated to employee mental health. This was in place at Massachusetts General

Hospital before the Marathon Bombing, and there is no doubt that after the bombing, employees benefitted as a result.

Currently, hospital leadership is continuing to emphasize the importance of mental health. Dr. Paul Biddinger is an emergency physician at Massachusetts General Hospital and the Chief of the Division of Emergency Preparedness. He sees mental health as a critical part of his work. Dr. Biddinger encourages all hospital staff and first responders to debrief together following a resuscitation. He also speaks publicly about his own emotional experiences during and after the Marathon Bombing, thus setting an example for his colleagues across the hospital. The hospital is currently exploring cutting-edge innovation that will move the needle on this issue. Application software can enable employees to “check in” so that they can monitor their own well-being, and be encouraged to access help when needed. Dr. Biddinger and his team are exploring this and other solutions to raising awareness and facilitating access to care.

Conclusion

First responders experience trauma as a regular part of their job. Perhaps not surprisingly, when compared to members of the civilian population, they experience heightened levels of depression, PTSD, suicidal thoughts, and more. First responders are more likely to die by suicide than to die within the line of duty. There is hardly any media attention devoted to this issue, contributing to a pervasive silence, shame, and stigma. These factors make it more difficult for first responders to access potentially life-saving mental health services.

It is time to raise awareness of this issue, both within the first responder profession and across the wider American public. Attention to this issue will lead to a removal of pragmatic and stigma-related barriers to care. Boston is a leader in the field, and it is time for the rest of the nation to follow in its footsteps. Also, in light of the leadership provided by Boston, there is the opportunity for Boston to continue to expand its leadership in the area. Commissioner Evans

alluded to policies including mandatory mental health check-ups and the automatic receipt of paid time off following exposure to critical incidents. Boston should take the lead in this area to demonstrate its commitment to our everyday heroes.

Methodology

Data on firefighter suicide was collected by the Firefighter Behavioral Health Alliance (FBHA), an organization that receives confidential reports on firefighter suicide through its website. For each reported suicide, the Founder of FBHA contacts the Chief of the deceased's fire department to validate the report. While FBHA is well-known among firefighters, many firefighters have not heard of the organization and therefore the number of reported suicides is an undercount of the actual number of suicides. FBHA estimates that approximately 40% of firefighter suicides are reported.

Badge of Life collected police suicide data through its web surveillance methodology. According to a publication released by the organization, "In this age of world web communications, a police suicide in even the smallest and most remote community is generally transmitted nationally and through police websites, forums, and blogs" (O'Hara, Violanti, Levenson, & Clark, 2013). As many as 55,000 websites are reviewed each year by organization staff.

Information about other mental health outcomes including depression and PTSD was gathered from academic journals by the lead author on this paper, a developmental psychologist. Information regarding innovation and opportunity nationally and in Boston was collected through several interviews with content experts, including the people listed as co-authors and contributors: Jeff Dill, Dr. Robert Douglas, Ron Clark, and William Evans. Other experts interviewed include: Lieutenant Patrick Hayes of the Boston Fire Department; Dr. John Herman,

Associate Chief, Department of Psychiatry at Massachusetts General Hospital; Dr. Paul Biddinger, Chief, Division of Emergency Preparedness, and Director, Center for Disaster Medicine at Massachusetts General Hospital; Dr. Rebecca Brendel, Medical Director, The One Fund Center.

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