RESPONDER**STRONG**

RESPONDERSTRONG™
The ResponderStrong group is committed to the belief that mental resiliency is vital to the overall performance and wellbeing of emergency responders from recruitment through retirement, as well as to their families, and the communities they serve. In partnership with the National Mental Health Innovation Center (NMHIC) at the University of Colorado Anschutz Medical Campus, ResponderStrong started in August 2016 with 35 members and has grown to more than 500 members as of January 2018. The group brings together representatives from Colorado law enforcement, emergency medical services (EMS), fire, and dispatch, as well as therapists and other experienced support professionals, to lead a social movement addressing responder mental health.

Functioning as an umbrella entity, our mandate is to create an accessible network of existing resources, identify gaps, creatively leverage existing expertise and broker partnerships to address unmet needs. Our intention is not to replace existing successful programs, but to supplement and expand them to areas that do not yet have sufficient coverage.
www.responderstrong.org

NATIONAL MENTAL HEALTH INNOVATION CENTER
The National Mental Health Innovation Center was established in 2016 with a mission to find, develop and put in to practice big new ideas to prevent, treat and change the way people think about mental illness. As part of the University of Colorado Anschutz Medical Campus, NMHIC has a unique role in connecting academic research, patient treatment and industry innovation to accelerate mental health solutions that have significant impact for patients and entire communities. NMHIC is the incubator for ResponderStrong. www.mentalhealthinnovation.org

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EXECUTIVE SUMMARY

This report outlines the findings from the **first of its kind statewide survey of emergency responder department leadership from police, sheriff, state patrol, fire, emergency medical services (EMS) and dispatch branches in Colorado**.

Supported by the National Mental Health Innovation Center, ResponderStrong™ members collaborated on the development and dissemination of the survey, and the collection and analysis of its responses.

The report is timely, as suicide is now recognized as the leading occupational killer of emergency responders. The number of high-profile mass casualty incidents in Colorado and the cumulative, daily exposures to stress and trauma have placed emergency responders at elevated risk for a range of adverse mental health impacts.

The main findings of the survey clarify the inherent challenges to maintaining mental health within the emergency response community. Leaders report mental health and resiliency funding and training to provide ongoing support are inadequate or unavailable, leaving emergency responders at risk. There are significant barriers that prevent responders from seeking help from what resources are available, and the effectiveness of the help is often sub-par. There also is a gap between rural and urban departments, with rural departments reporting even more challenges.

In addition, there remains a persistent mindset among many responders that can be unforgiving of any admission of "weakness" – meaning stigma is a significant cultural challenge.

Despite those warning signs, there are opportunities for improvement. Leaders responding to this survey recognize that daily mental health support is necessary for mental and emotional resiliency, and they recognize the current shortfalls in providing that support – the first step toward addressing problems. They are calling for a culture change to propel a state of wellness and resiliency that, too often, proves elusive for many responders.

WHAT WE LEARNED

1 **Leaders recognize the need for day-to-day mental health supports**

Leaders are moving from a traditional focus on external crisis-directed services toward the incorporation of day-to-day services and trainings to address the mental and emotional stressors of the job.

2 **Agencies face consistent systemic barriers**

Consistent systemic barriers across branches limit the utilization and effectiveness of mental health supports.

3 **Agencies face consistent cultural barriers**

Consistent cultural barriers across branches present critical obstacles to effective mental health support.

EXECUTIVE SUMMARY (CONT.)

The overarching message from leaders taking part in this survey is that they need help in addressing mental health in their ranks, and they need it now.

The mental strains, stressors and traumas of emergency responders are daily, cumulative and significant. While many responders do cope successfully with these pressures, no one is immune to them. Leaders recognize that and are eager to protect their personnel through practical, workable solutions that ensure mental wellness is prioritized and successfully supported.

More than half (55%) of the 768 emergency response leaders across Colorado responded to the survey. Throughout this report, you will see summaries of their quantitative responses. Further, you will see a representative sampling of the comments leaders provided in open queries. These qualitative comments add important insights beyond the numbers.

ResponderStrong is harnessing the energy and passion of responders from across the state. This survey contains information that better informs and guides the initiative to create effective solutions for responders and their agencies. The findings are being used to guide this grassroots movement with the goal of better supporting mental health among emergency responders in Colorado. These data are used to identify and boost areas of strength while also identifying areas where more attention is needed.

The problems and the most effective solutions are being defined by emergency responders; we are taking care of ourselves and our own.

INTRODUCTION

Suicide is recognized nationally as the leading occupational killer of emergency responders. From 2004-2014, three times more Colorado police officers died by their own hand than by all other line of duty deaths (LODD) combined[1] and suicides for Colorado firefighters outpaced other LODD causes by 50%.[2] While data for LODD within the dispatch and EMS communities for that period was not tracked as thoroughly, suicide is recognized as a pervasive issue within these branches.

Every day, emergency responders face stressful and disturbing situations, and are frequently called to scenes of traumatic injury and death. Exposure to these critical incidents puts us at high risk for:

- **Post-traumatic symptoms**
  (sleep problems, flashbacks, heightened reactivity)

- **Anxiety and depression**

- **Substance abuse and addiction**

- **Strained social relationships and divorce**

- **A decreased ability to perform duties**

Exposure to daily or critical event trauma can compromise our abilities to be there for our brothers and sisters in uniform, and to protect and defend our community.

In the responder culture, mental health is often not addressed proactively but rather in reaction to an adverse event, often a significant mass casualty event or a responder suicide.

In the summer of 2017, the ResponderStrong group surveyed all known emergency response leaders in Colorado (based on available registers from managing agencies) to gauge the state of mental health supports for responders. This is the first statewide query to cross branch boundaries (police, sheriff, state patrol, fire, EMS and dispatch) to address mental health concerns among emergency responders as a unified entity.

Most emergency response leaders draw from extensive personal field experience. Leaders also have a broader overview of the dynamics (political, legislative, and social) that govern emergency services. The survey is intended to assess the perceptions of emergency response leaders in Colorado regarding the status of mental health awareness and supports within their agencies. The survey also gives leaders a chance to offer any additional insights in open-ended, qualitative questions.

> **❝ It is past time, with the dramatic increase in first responder suicides, to move toward a regional/professional group to deal with the mental health issues.**
>
> *Source: ResponderStrong Survey*

INTRODUCTION (CONT.)

Of the 768 Colorado leaders contacted, 424 responded – a strong 55% response rate. The map below highlights every zip code from which we received a response.

LEGEND

State Boundary	County Boundary	COLORADO ZIPCODES:	No Data		Completed Survey
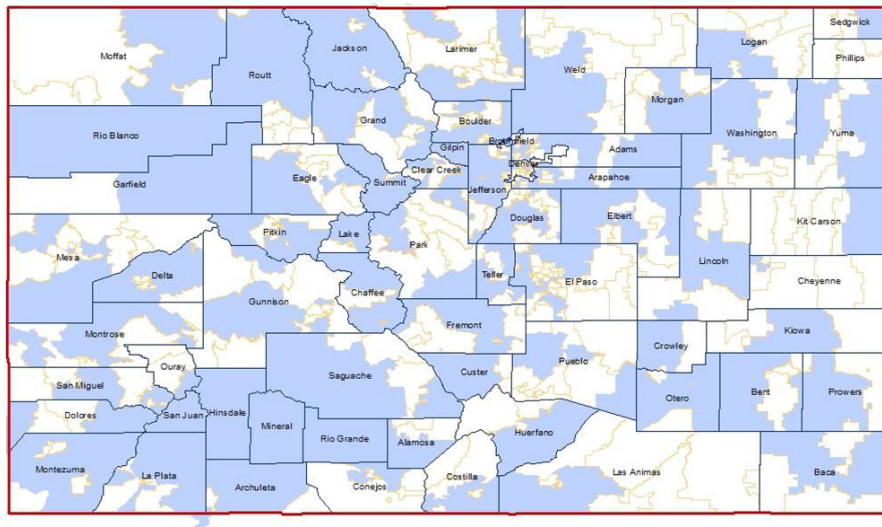
[Note: each agency is represented by a sole zip code although responder service coverage often includes neighboring zip codes.]

ResponderStrong is harnessing the energy and passion of responders from across the state. This survey contains information that better informs and guides the initiative to create effective solutions for responders and their agencies. The findings are being used to guide this grassroots movement's goal of better supporting mental health among emergency responders in Colorado by identifying and boosting areas of strength while also identifying areas where more attention is needed. The problems and the most effective solutions are being defined by emergency responders; we are taking care of ourselves and our own.

While this initial survey seeks the perspective of leaders, we know that any lasting change in our community must be approached from both the top down and the bottom up.

The following report outlines three key findings, followed by a summary of the call to action from the leaders' perspective.

FINDING 1

Leaders are moving from a traditional focus on external crisis-directed services toward the incorporation of day-to-day services and trainings to address the mental and emotional stressors of the job.

Historically, leaders have focused on supporting responders in the wake of critical incidents, hence the prevalence of Critical Incident Stress Debriefing (CISD) programs across Colorado. The emergency responder community started with the view that critical incidents were the primary stressor, failing to recognize the cumulative impacts of "lesser" stressors. While CISD provided by an outside entity can be very helpful in the wake of a major event, leaders are recognizing that CISD alone is not enough.

Survey results show that leaders are aware that resiliency in crisis is dependent upon daily support of mental preparedness and that many are instituting day-to-day supports to address the cumulative smaller stressors that can overwhelm responders. When queried as to the support services available within their agencies, leaders identify an evolution of thought in their approach to mental health – citing resources and trainings beyond one-time responses to critical incidents.

The top six available services cited by leaders are Critical Incident Stress Debriefing (CISD), peer support, a licensed mental health professional, chaplaincy, conflict resolution and Employee Assistance Programs (EAPs).

Critical and Daily Supports Available to Colorado Agencies

Service	Percentage
Critical Incident Stress Debriefing (CISD)	90%
Peer support	78%
Licensed mental health professional	68%
Chaplaincy	63%
Conflict resolution	63%
Employee Assistance Program (EAP)	62%
Substance abuse program	58%
Financial counseling	37%
Retirement transition support	30%
Family nights/family support groups	23%

> " We speak of mental wellness for our members, but we do not use the resources unless it is a high profile event. The everyday grind of being a law enforcement officer probably takes more of a toll on members than what is admitted.

> " When we have had some critical incidents, counselors have been brought in. But we have had multiple critical incidents that have happened and there was no support for the officers involved or any debriefs because our management decided that they were not critical enough.

FINDING 1 (CONTD.)

CRITICAL INCIDENT STRESS DEBRIEFING

Critical Incident Stress Debriefing (CISD) services are available to 90% of responding agencies (91% of urban and 87% of rural). This prevalence is likely due to the initial focus of leaders on critical incidents as the primary source of career stress. CISD was one of the first occupationally accepted mental health interventions. As a result, systems like the Colorado Crisis Support Network were created.

IN-HOUSE SUPPORTS

Leaders are making in-house supports more widely available, with peer support evolving as an internal resource:

- **75% of leaders report that their agencies now have access to peer support (80% of urban respondents and 73% of rural)**
- **78% of leaders expressed an explicit interest in developing regional supports, with equal interest from both rural and urban agencies**

Many qualitative comments highlight the success of department peer support teams. Chief among the strengths of this approach is the foundation of shared experience among responders. Talking to someone who has been in a similar place, who can normalize the experience, and who can help navigate the path to additional resources when needed is appealing to responders. As responders, we routinely entrust our physical safety to our co-workers. Peer support offers a means to likewise entrust our emotional and mental safety to trusted peers.

As peer support encounters issues beyond the ability to be managed by trained peers, leaders recognize the importance of establishing or maintaining a network of providers for specialized support, including:

- **Licensed mental health professionals are available to 68% of agencies (71% urban and 60% rural)**
- **Employee Assistance Programs (EAPs) are available to 62% of agencies (71% urban and 39% rural)**

The growing recognition of the spiritual stressors of the work (in addition to the physical, mental and emotional) has expanded to more fully engage chaplaincy services, a support with rich history in the responder world. Chaplains are widely recognized as an integral contributor to the mental health support of emergency responders with 64% of urban and 60% of rural agencies reporting access. For rural agencies, chaplaincy is as common as licensed mental health providers.

> **"** When we have had a critical incident, counselors have been brought in. There is no local counselor for the daily life struggles law enforcement have to deal with.

> **"** Individual mental wellness is still not a topic that is widely discussed in our department. The concept of peer support has slowly evolved into a trusted resource.

> **"** We have spent money on training in peer support and crisis management, but do not have the covering of qualified mental health professionals in this area.

FINDING 1 (CONT.)

As the prevalence of adverse impacts of overwhelming stress are being recognized, medical programs to address the physical manifestations, such as substance abuse, have been added. In the survey, substance abuse programs are available to responders within 58% of agencies (64% urban and 43% rural).

FAMILIES AND RETIREMENT

Fewer leaders report providing services for families and retirees. Family members are often the first to notice stress-driven changes in their responder, but currently:

- **Only 23% of agencies report hosting family nights or family support groups (27% urban and 15% rural).** However, as one rural leader notes, some smaller communities tend to provide family support in an informal manner.

As we become aware that retirement can bring a loss of identity, structure and support, we see retirees who become vulnerable to the impact of the unaddressed, cumulative trauma in their careers, succumbing to adverse outcomes, including suicide. To date:

- **Only 30% of respondents (35% urban and 18% rural) report providing retirement transition supports**
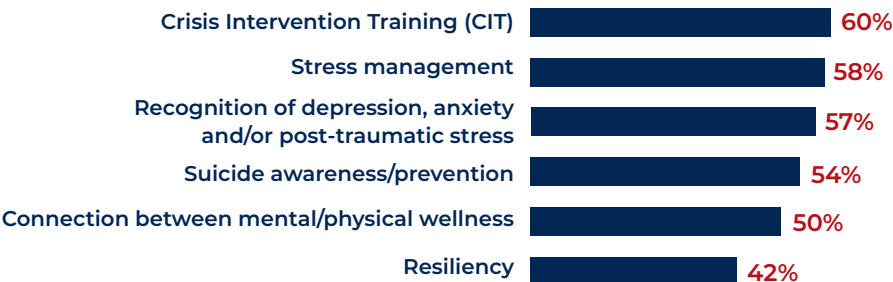
To better support families and retirees, it is in our common interest that leaders continue to move beyond providing mainly post-critical incident services to an evolving focus on delivering mental health support over the length and breadth of responders' lives.

TRAININGS

Crisis Intervention Training (CIT) is the most commonly offered mental wellness training, occurring predominantly within law enforcement and dispatch. However, this training focuses on the mental health issues of community members in crisis, not on the mental health of responders themselves. Nearly half of all leaders report the absence of trainings that target the daily stress and trauma of the job, including stress management and awareness of depression, anxiety, post-traumatic stress and suicide.

The survey question did not differentiate between one-time trainings or trainings offered in regular rotation. Leaders tell us that trainings need to be in regular rotation to affect cultural change and to validate the priority of mental health among responders.

> **The more that mental wellness is talked about, the easier it will be for first responders to lower the stigma that comes with seeking assistance.**

Single or Recurring Trainings Available within Colorado Agencies

Training	Percentage
Crisis Intervention Training (CIT)	60%
Stress management	58%
Recognition of depression, anxiety and/or post-traumatic stress	57%
Suicide awareness/prevention	54%
Connection between mental/physical wellness	50%
Resiliency	42%

FINDING 2

Consistent systemic barriers across branches limit utilization and effectiveness of mental health supports.

While leaders note the increasing availability of critical services and trainings, they also describe the consistent barriers to the utilization and effectiveness of these supports for responders in their agency. We learn from leaders that availability is not enough: accessibility, repetition of the message, expansion of the content and compatibility with the responder mindset are the key factors. Leaders explain that resources across branches are often limited in their effectiveness by a lack of sensitivity to the responder culture and familiarity with the presence or impacts of trauma.

Leaders identify the top systemic barriers to providing more effective mental health services for personnel, ranging from lack of funding to lack of time for training.

Top Systemic Barriers to More Effective Mental Health Services

Lack of departmental funding — **50%**

High out-of-pocket costs for private mental health services — **40%**

Lack of local counselors/psychologists — **34%**

Lack of training time for mental health training — **31%**

❝ As a small agency with limited funds and time, we have not prioritized mental health. That will probably continue to be the case unless we have a significant event and additional funding.

❝ We would like to focus training efforts on this area and probably should. As with everyone, we have training priorities...and only so much time and so much money.

❝ Mental health needs to be required training during academies and field training, and ongoing training for all.

DON'T KNOW **20%**

NO FUNDS **46%**

> $4K **9%**

$1 - $4K **25%**
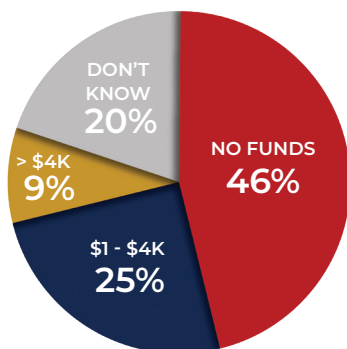
LACK OF DEPARTMENTAL FUNDING

Across branches, only 29% of leaders report that the funding their agency has for mental health training is adequate.

Two-thirds of all leaders report either having zero funds for mental health training (38% of urban and 63% of rural) or not knowing whether funds exist.

Just one-third of agencies have any funds dedicated to mental health (39% of urban and 23% of rural agencies).

FINDING 2 (CONT.)

HIGH OUT OF POCKET COSTS AND
LACK OF LOCAL COUNSELORS/PSYCHOLOGISTS

Barriers to seeking mental healthcare are two-fold: the cost and the scarcity of providers in local areas.

Leaders report high out-of-pocket costs required for private mental healthcare as a significant barrier to effective mental health support for responders. Many responders do not have access to financial assistance for care. Those who do often find it challenging to continue mental healthcare after exceeding the low- or no-cost session allowance from EAPs or agencies.

Leaders also report an insufficient supply of local mental health providers, particularly in rural communities. Rural leaders note long travel times and lengthy wait times for appointments as demoralizing deterrents to seeking mental healthcare.

## LACK OF TRAINING TIME
FOCUSED ON RESPONDER MENTAL HEALTH

The traditional preference for responders' training has been face-to-face delivery in a classroom or drill ground setting, requiring valuable blocks of time in already overcrowded training calendars, in-house educators to act as subject matter experts and funding to support the program. Numerous delivery barriers are inherent in this training format.

In addition, much of the training that is reported to be in regular rotation teaches responders to recognize the signs of severe mental illness in others, rather than the cumulative impacts of stressors within themselves and their colleagues. This raises a concern for inadvertently increasing stigma around mental health by focusing training on the mental illness issues of the community rather than the mental health impacts on the responders.

> **"** Right now, there is one mental health provider we can call on, an hour away if needed, but no one local/affordable that has a public safety understanding.

> **"** The biggest hurdle we have is no trained psychologist and psychiatrist in our area (the Western Slope).

> **"** I believe we have some gaps in resiliency training and substance abuse/suicide training. It is my hope that we, as a department, will find more time in the training calendar to address these topics.
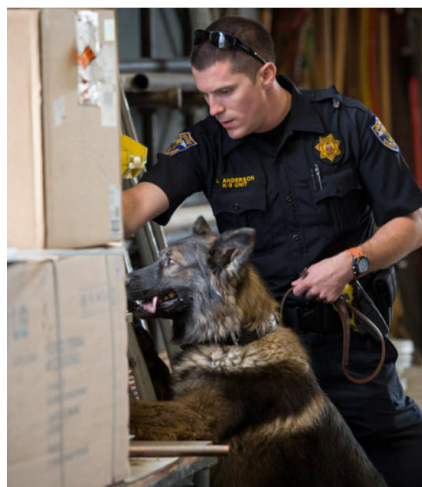
FINDING 3

Consistent cultural barriers across branches present critical obstacles to effective mental health support.

Responders tend to hold themselves to a high personal standard, viewing themselves as the rescuer, not the one who needs rescuing. The culture tends to be unforgiving of any admission of "weakness" or emotional impact. As a result, responders are concerned about maintaining confidentiality and not adversely impacting their opportunities for promotion. Often, the cultural stigma is internalized, creating shame around the experience of depression, anxiety and substance abuse, and preventing recognition of the often-undiagnosed trauma that underlies those conditions.

The stigma against acknowledging mental health problems among responders is deeply ingrained. Leaders note that mental health impacts are widely treated as a weakness rather than as an expected potential on-the-job injury.

Most leaders report that emergency responders in their departments are not comfortable talking about their own mental health, do not know how to recognize symptoms of mental health or substance abuse issues within themselves, and do not know how to seek help for a mental health or substance abuse problem.

In a series of questions asking about agency culture, leaders were asked to rate questions on a scale from 1 (not true) to 7 (very true). For this report, we collapsed categories into "not true" (1-2), "somewhat true" (3-5), and "very true" (6-7).

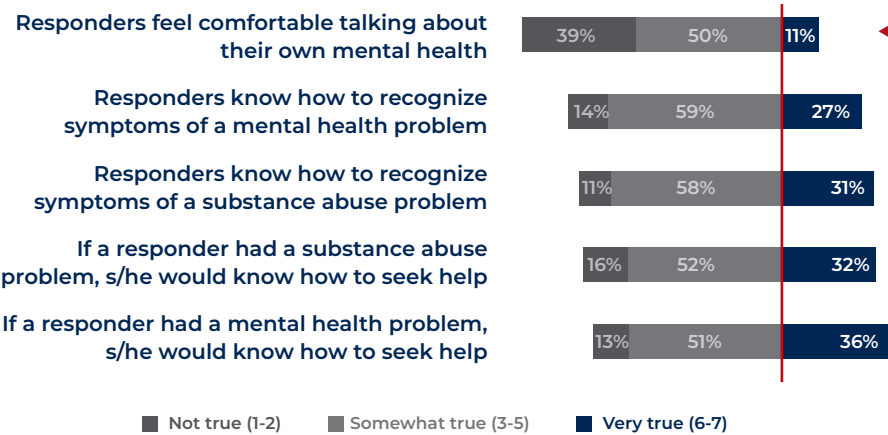A minority of leaders reported the following to be "very true":

- **11% of leaders believe that responders feel comfortable discussing their own mental health**

- **27% believe their personnel know how to recognize symptoms of a mental health problem and 36% believe they would know how to seek help for this problem**

- **31% believe their personnel know how to recognize symptoms of a substance abuse problem and 32% believe that responders would know how to seek help for the addiction**

> ❝ A lot of times, we are very reluctant to bring a mental health issue forward until it is too late or we get ourselves into trouble – emotionally, legally or physically.

> ❝ We have a culture in our area that you are seen as 'weak' if you reach out. In this line of work, we know that's far from the truth. We need a strong leader, some check points and trainings for dispatchers to make sure we maintain a healthy mindset.

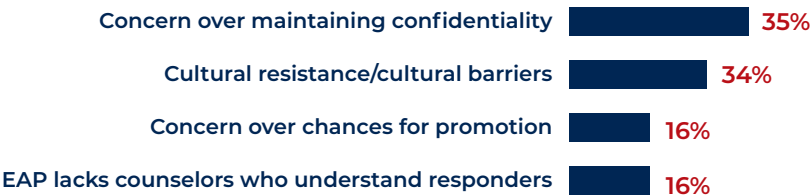## Leaders' Perception of their Agency Culture

	Not true (1-2)	Somewhat true (3-5)	Very true (6-7)
Responders feel comfortable talking about their own mental health	39%	50%	11%
Responders know how to recognize symptoms of a mental health problem	14%	59%	27%
Responders know how to recognize symptoms of a substance abuse problem	11%	58%	31%
If a responder had a substance abuse problem, s/he would know how to seek help	16%	52%	32%
If a responder had a mental health problem, s/he would know how to seek help	13%	51%	36%

◄ **ONLY 11% OF LEADERS** indicate that responders feel comfortable talking about their own mental health

About one-third of all leaders cite concerns over maintaining confidentiality and cultural resistance as the top cultural barriers to their department providing more effective mental health services.

Top Cultural Barriers to More Effective Mental Health Services

Concern over maintaining confidentiality	35%
Cultural resistance/cultural barriers	34%
Concern over chances for promotion	16%
EAP lacks counselors who understand responders	16%

CULTURAL COMPETENCY OF PROVIDERS/SUPPORTS

Although 62% of responding agencies report providing EAP services (71% urban and 39% rural), the qualitative responses point to concerns with the cultural competency of the available EAP providers.

The barrier is two-fold: the systemic lack of licensed mental health professionals in many regions and the lack of familiarity or insight into the responder culture among those professionals.

Arguably, when it comes to therapeutic outcomes, poor service is worse than no service as it can discourage further help-seeking behaviors. There is a perceived shortage of providers who understand not only the occupational culture but also unique issues that impact the responder, such as the trauma exposures inherent in the job, required performance standards, the work environment, shift schedules, fitness for duty, the worker's compensation statute and restricted duty.

❝ We have found that the currently available CISD and EAP programs are not as effective as we feel they should be in dealing with first responder mental health issues.

FINDING 3 (CONT.)

Occupational trauma crosses branches, but specifics of the work environments do vary within these branches. Some responders work in relative isolation while others are crew based. Due to the 24/7 nature of the work, shifts vary from short but frequent hours to longer but more infrequent work cycles. All branches cited sleep and circadian disruptions due to their schedules.

Along with leaders from all branches citing a responder culture that does not support acknowledging emotional impacts or seeking mental health support is the acknowledgment of little time to process stressful occupational incidents.

Only 38% of leaders believe there is adequate time for responders to process stressful incidents at work, with some branches significantly lower (EMS: 51%; fire: 46%; police: 38%; sheriff: 29%; dispatch: 23%; and state patrol: 20%).

These data beg the question, when do responders have the time to process stressful work incidents? If not at work, is it during the commute, at home with family or on their own time? Does the culture encourage compartmentalizing events rather than acknowledging them to save face and time, allowing the events to accumulate until they become something that can no longer be ignored, but are now too overwhelming to manage alone? Where are the tools that responders can use to help this process? Are they taught and practiced through work for deployment in life when the responder needs to process?

❝ The people that work for the EAPs are not informed enough to have the discussions with the responders to help with PTSD. My guys have said they spend more time telling counselors what they do than discussing the events or what they are going through mentally.

❝ I have personally worked with our EAP to find counselors who have knowledge of the line of work we are in, but have hit a brick wall in being able to verify what background or knowledge the counselors have. It would be nice if there was an EAP specific for Fire, Police or EMS and not one that is used in such a broad spectrum of businesses. Is there an EAP provider that just provides service to first responders?

CALL TO ACTION

The systemic and cultural barriers to providing effective mental health supports for responders are interdependent. Unless we change our culture to increase acceptance of mental wellness as essential to optimal functioning, the best systems will not be utilized. Once we do affect this necessary shift in culture, the suitable support systems need to be in place to sustain the momentum.

Most leaders recognize the necessity for improved mental health supports. They are calling for culture change, easily accessible education materials, assistance in delivering the mental health message consistently across the career, improved mental health resources and increased engagement of families.

Based on the barriers so clearly described by the respondents, we hear that our strategies must be:

1. **COLLECTIVE**

2. **COMPREHENSIVE**

3. **INNOVATIVE**

COLLECTIVE: Collective supports cross agency lines, branch boundaries and support specialties (mental health providers, chaplains, EAPs, support foundations, educators, mindfulness teachers and medical professionals).

- Many agencies report that, on their own, they lack the resources, time, funding and ability to adequately support the mental health of their members.

- The mapping of resources shows that **in many regions, one branch houses resources that other local branches have not yet been able to develop**. The qualitative data recount success stories from groups of agencies who have successfully combined resources to better serve all their personnel.

- The intention of ResponderStrong is to encourage responders to think of themselves as emergency responders rather than solely as members of their individual branches. Through this shift in perspective, seeing similarities in experiences and challenges, mental wellness supports become less fragmented. The number of emergency responders across all branches and their available resources can grow, leading to culture change that can be more readily effected and sustained.

CALL TO ACTION (CONT.)

COMPREHENSIVE: A comprehensive approach is multi-faceted over the career. Providing comprehensive supports across the mental and emotional injury spectrum with improved identification and treatment for existing injuries is the top priority. Developing widespread responder awareness and resiliency skills to prevent future injuries is the next phase. Expanding these supports to reach families and to follow responders after service are also essential steps to reduce the negative impacts of responder career stress.

- We can **improve the treatment of the existing acute and chronic stress injuries** within our field through better networking of existing resources and tailoring new resources to meet the needs and barriers described by the community.

- By developing standards for cultural competency, including trauma education, we can **assist mental health providers in acquiring the knowledge and experience to better serve** their responder clients and families. Thereby, we expand coverage of services to be more commensurate with the exposures and trauma so that care is comprehensive and healing.

- There is a need to **expand services and coverage beyond the responder** to families and beyond retirement or separation of service to include life after the career.

INNOVATIVE: Many of the systemic barriers are artifacts from the traditional approaches to providing training. Leaders tell us time and money are their biggest systemic barriers. With the digital innovations available today, education can be presented, and skills taught with minimal additional burden to budgets or the training calendars. **Accessibility to both education and mental health counseling can be improved via existing and emerging technologies**.

CALL TO ACTION (CONT.)

The recognition by leaders of the importance of mental wellness training, the negative impact of cumulative stress on responders, and the constraints of both money and time, suggest that **a restructuring of priorities and training modalities is due**. If agencies prioritize their training based on the most frequent and greatest threats to responders, mental health should be among the main topics of focus.

- Leaders tell us they would prefer face-to-face training structures, yet they also point out the seemingly insurmountable time and money barriers created by adherence to this traditional training format. Innovative approaches can include incorporating intensive and consistent mental wellness content in responder's initial career training, whether that be within the college system or in the academy setting. Educators in this early stage can serve as powerful cultural change agents who normalize mental health issues.

- Legitimizing mental wellness as a relevant and necessary topic, as important as other teachings on life safety and preparedness, is essential to shift the training priorities and the acceptance of the message.

- We can honor confidentiality through innovative approaches that allow members to self-assess, explore vetted materials through a trusted online portal, and be directed to effective supports.

CONCLUSION

Survey respondents were clear that, as leaders, they want and need help in addressing mental health issues in their departments. Collectively, they present a unified voice around an urgent need.

Key findings covered in this report include the significant lack of mental health resources, particularly among rural agencies. Not surprisingly, time, money and culture were identified as the largest barriers to the delivery of effective mental health supports among responders.

Only 11% of leaders report that their personnel are comfortable discussing their personal mental health. The primary reason cited is the cultural stigma of viewing mental and emotional turmoil as weakness rather than a likely outcome of cumulative occupational exposures.

Less than one-third of leaders believe their funding for mental health is adequate. And throughout all branches, leaders report a lack of mental health counselors who are specifically trained in the needs of emergency responders, as well as a lack of time in their training schedules for resiliency reinforcement.

The survey clarifies the needs based on regions. Respondents point to resources in their communities that are available to some response agencies but potentially could be made more widely available with better communication and planning.

Finally, the survey also reveals what resources and practices are working, albeit in limited scope. These include regional peer support in some areas, pockets of culturally competent mental health providers and family support networks.

We do see successful resources and efforts in limited areas that, if expanded, could prove beneficial. But the reality is that too many responders are falling through the gaps.

Our hope is that this report and its findings will spur dialogue and action among stakeholders to improve the lives and health of emergency responders. Potential solutions that may be explored by the emergency responder community include, but are not limited to: regional peer support; telehealth-based mental healthcare, which has proven effective within other niches, including the military; innovative new training platforms including mobile and digital technologies like virtual reality; and ongoing mental health components within training schedules.

ResponderStrong members will use this report to further their resiliency work. For more information regarding the ResponderStrong programs in development and to watch how the survey findings shape their future, please visit www.ResponderStrong.org.

GLOSSARY

Career: Paid, full-time personnel working for an emergency response agency.

Chaplain: A member of the clergy attached to an emergency responder organization to provide counseling and spiritual support.

Critical Incident Stress Debriefing (CISD): "A formalized, structured method whereby a group of rescue and response workers reviews the stressful experience of a disaster. CISD was developed to assist first responders, such as fire and police personnel; it was not meant for the survivors of a disaster or their relatives. CISD was never intended as a substitute for therapy. It was designed to be delivered in a group format and meant to be incorporated into a larger, multi-component crisis intervention system labeled Critical Incident Stress Management (CISM)." *From: www.ptsd.va.gov/professional/trauma/disaster-terrorism/debriefing-after-disasters*

Critical Incident Stress Management (CISM): "CISM includes the following components: pre-crisis intervention; disaster or large-scale demobilization and informational briefings (town meetings); staff advisement; defusing; CISD; one-on-one crisis counseling or support; family crisis intervention and organizational consultation; follow-up and referral mechanisms for assessment and treatment, if necessary." *From: www.ptsd.va.gov/professional/trauma/disaster-terrorism/debriefing-after-disasters*

Crisis Intervention Team (CIT): "A model for community policing that brings together law enforcement, mental health providers, hospital emergency departments and individuals with mental illness and their families to improve responses to people in crisis. CIT programs enhance communication, identify mental health resources for assisting people in crisis and ensure that officers get the training and support that they need." *From the National Alliance on Mental Illness: www.nami.org*

Emergency Responders (per the scope of this work)**:** ResponderStrong currently involves emergency responders working in law enforcement (police, sheriff and state patrol), fire, EMS, and 911 dispatch.

Employee Assistance Program (EAP): A benefit program provided by many employers to help employees manage personal issues in the financial, legal and mental health arenas via information, consultation and support. The program is intended for short-term use.

Line/field personnel: Personnel whose primary duties are field- or line-based, working within their response areas rather than serving the agency in an administrative capacity.

Line of Duty Death (LODD): A death of an emergency responder that results from the performance of his/her occupational duties as a responder.

GLOSSARY (CONT.)

National Mental Health Innovation Center: The National Mental Health Innovation Center (NMHIC), located on the University of Colorado Anschutz Medical Campus, works to accelerate bold new mental health solutions that have significant impact for individuals and entire communities. NMHIC is the incubator for ResponderStrong.

ResponderStrong™: A collaboration between emergency responders (law enforcement, fire, dispatch and EMS) and the National Mental Health Innovation Center, working across branch boundaries to support robust mental health among emergency responders in Colorado.

Urban and rural: The U.S. Census Bureau identifies two types of urban areas, with all other areas defined as rural:

- Urbanized Areas (UAs) of 50,000 or more people
- Urban Clusters (UCs) of at least 2,500 and less than 50,000 people
- Rural encompasses all population, housing, and territory not included within an urban area

For our analysis, we created a dichotomous variable based on percent of population located in rural areas from the U.S. Census Bureau (2010):

- 50% or more rural population = rural
- Less than 50% rural population = urban

Volunteer: Unpaid personnel who apply, train and respond to emergencies for a volunteer-based emergency response agency, typically found in rural areas.

Worker's Compensation: State statute that recognizes certain injuries as being occupational in nature and therefore covered by the employing agency.

METHODOLOGY

This is the first year of a longitudinal survey of leaders across Colorado designed to track changes in agency mental wellness needs and assets over time. Survey data for this report were gathered through leadership surveys collected between May and July 2017.

The survey was collaboratively developed by more than 20 ResponderStrong members. Anna Joseph of the National Mental Health Innovation Center assisted in the formation of survey questions and dissemination strategy. The survey asked leaders more than 40 questions about their agency's mental wellness services and trainings as well as barriers to their delivery. A closing open-ended question asked for any additional thoughts regarding emergency responder mental wellness (adapted from the National Association of Emergency Medical Technicians 2016 survey). One-third of respondents answered this question, elaborating on the survey topics and often sharing in-depth commentary.

The complete survey is available upon request.

Surveys were sent to the lead within each agency through the online platform, Qualtrics. We identified leaders through membership lists from key state agencies overseeing each branch. Public, private and volunteer EMS agencies providing 911 service were surveyed. Corporate fire agencies, military and airports were not surveyed. Leaders had the option of completing the survey themselves or asking a representative from their agency to complete it, such as the wellness coordinator. In most cases, the leader completed the survey him or herself.

Of the surveys sent to the 768 leaders in the state, 424 responded. The overall response rate was a strong 55%. Responses varied by branch: sheriff: 71%; dispatch: 69%; police: 67%; state patrol: 67%; EMS: 45%; and fire: 45%. Of these 424 responses, 69% were from urban areas (population greater than 2,500) and 31% were from rural areas. Email addresses and phone numbers for smaller volunteer departments were at times not current, which may help explain this variation.

ResponderStrong members participated in extensive community outreach to boost the response rate. We informed Colorado emergency responder groups about the survey goal of establishing a statewide emergency responder mental health resource and needs baseline and asked those groups to include a description of the survey in their newsletters or announcements.

APPENDIX (CONT.)

ResponderStrong members also made individual phone calls to leaders to invite them to participate and to answer any questions.

This report includes basic descriptive analyses of the survey data. No weighting was applied. Christine Velez and Bridget Nuechterlein of The Evaluation Center at the University of Colorado Denver were instrumental in creating GIS (Geographic Information System) maps and graphs with the survey data. Qualitative responses from the open-ended question were coded in NVivo by theme. The quotes from the qualitative responses shared throughout this report reflect repeated themes in the data.

NOTES

1. Jamison, Herndon, Bui, and Bol (2015) analyzed first-responder suicides using the Colorado Violent Death Reporting System, a public health surveillance system implemented at the Colorado Department of Public Health and Environment in 2004. Between 2004-2014, 95 suicides in Colorado were reported among police/law enforcement and corrections. Jamison, E., Herndon, K., Bui, A.G., and Bol, K. (2015). *Suicide Among First Responders in Colorado, 2004-2014: A Summary from the Colorado Violent Death Reporting System*. Retrieved from http://cdpsdocs.state.co.us/safeschools/Resources/dphe/SuicideinColoradoFirstResponders.pdf

The Officer Down Memorial Page, Inc. tracks law enforcement deaths every year, by state, in the U.S. Between 2004-2014, 26 LODD deaths in Colorado are reported on the agency website. Retrieved from https://www.odmp.org/search?name=&agency=&state=Colorado&cause=&from=2004&to=2014&filter=all

2. Between 2004-2014, there were 21 suicides in Colorado among firefighters (Jamison, Herndon, Bui, and Bol, 2015). Every year during this same period, the U.S. Fire Administration (USFA) has tracked the number of on-duty firefighter fatalities. Between 2004-2014, these annual USFA reports list 10 total firefighter fatalities in Colorado. For the latest report used for this analysis, see United States Fire Administration (2015). *Firefighter Fatalities in the United States in 2014*. Retrieved from USFA Website: https://www.usfa.fema.gov/downloads/pdf/publications/ff_fat14.pdf