BEHAVIORAL HEALTH AND WELLNESS

A ROADMAP FOR KING COUNTY FIRST RESPONDERS

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Why a Roadmap?

Bottom Line up Front:

Mental and behavioral health needs for first responders of all kinds are significant, and increasing. Departments all over the country are recognizing the need for substantive, high-quality and resourcebacked programming and training that supports the health and wellness of our responders. Behavioral health is something that contributes to safety on the job [1] [2], longevity and health in response work[3], and better outcomes after retirement[4]. When the right kind of training and programming is provided throughout the spectrum of a career in response, you get much healthier crews, and you have the opportunity to divert and prevent more serious crises from unfolding and taking people off the job for long periods of time. Effective and efficient behavioral health programming, including a robust and operational peer-support team and network, are essential to the well-being and longevity of anyone in a response role. In addition to the direct "human" benefits, orienting resources to this aim is cost-effective for departments and reduces the stigma[5] [6], that still strongly exists around needing to ask for help.

This roadmap was created following a series of focus groups with departments, groups, representatives and teams from all over King County, and we extend sincere thanks for their participation in this process.

[1] SAMHSA. 2022. ***"Expanding Implementation of Mental Health Awareness Training (MHAT) in the Workplace."*** Substance Abuse and Mental Health Services Administration, 8 (August).

[2] Lee et al., 2024. ***"Interplay between Safety Climate and Emotional Exhaustion: Effects on First Responders' Safety Behavior and Wellbeing Over Time."*** Journal of Business and Psychology, 209-231. https://doi.org/10.1007/s10869-022-09869-1.

[3] Lowery, A., & Cassidy, T. (2022). Health and well-being of first responders: The role of psychological capital, selfcompassion, social support, relationship satisfaction, and physical activity. Journal of Workplace Behavioral Health, 37(2), 87–105. https://doi.org/10.1080/15555240.2021.1990776

[4] Smith, Erin & Dean, Greg & Holmes, Lisa. (2021). Supporting the Mental Health and Well-Being of First Responders from Career to Retirement: A Scoping Review. Prehospital and Disaster Medicine. 36. 1-6. 10.1017/S1049023X21000431.

[5] Hawrilenko M, Smolka C, Ward E, et al. Return on Investment of Enhanced Behavioral Health Services. JAMA Netw Open. 2025;8(2):e2457834. doi:10.1001/jamanetworkopen.2024.57834

[6] Wright HM, Fuessel-Hermann D, Pazdera M, Lee S, Ridge B, Kim JU, Konopacki K, Hilton L, Greensides M, Langenecker SA, Smith AJ. Preventative Care in First Responder Mental Health: Focusing on Access and Utilization via Stepped Telehealth Care. Front Health Serv. 2022 Jun 9;2:848138. doi: 10.3389/frhs.2022.848138. PMID: 36925868; PMCID: PMC10012773.

The focus group participants all contributed their time and expertise to making sure that the information contained here is relevant to the region, on track with the goals held by many, realistic about the challenges that face us in advancing this work, and consistent with other existing roadmaps such as this one from the First Responder Center For Excellence. Whether you are unsure where to start with advancing wellness and behavioral health, or you have a strong program underway and want to improve it, this roadmap was designed to help clarify those next steps.

Purpose

The purpose of this document is to provide first responder departments in the King County region with a set of descriptions, guidelines and suggestions for how to evaluate and advance behavioral health and wellness programming and support implementation. The aim here is to provide enough detail about "next steps" and concrete actions that may be helpful to take in order to advance wellness outcomes, but also to generalize best-practices so that they are applicable to most groups and departments in the region.

Contents and Orientation

#1 Background and introduction

Provides detail and context for the situation we are all facing with behavioral health including historical, national and regional data.

#2 Stages

This section is broken into 6 parts. Each of the six stages is described by the presence or lack of certain behavioral health and wellness emphases, programming or operational norms, elements of culture that are department specific, training and cross-departmental collaboration opportunities. A self-assessment checklist is available in Appendix A to help determine which stage is the right place to start for your department, group or team.

#3 Career phase recommendations

This section is dedicated to a topic that came up in EVERY focus group; the need for specific career-phase related behavioral health programming and support. What you will find in this section are recommendations to consider for early career, mid-career, and late-career specific issues and strengths.

#4 Resources and references

This section is a compiled list of resources that colleagues from around the region use to support their behavioral health programming and peer-support. It also includes external therapy referral resources, out-of-state options, specialty services, and IAFF resource links.

Challenges

There were several sizable challenges that were immediately clear with this project. They are listed here along with some explanation about our work to mitigate their impact.

Challenge 1

Needing to generalize recommendations to be useful for the wide variety and sizes of responder departments that this roadmap is designed to support **AND** being specific enough to be actually useful.

Challenge 2

Communicating the wrap-around benefits of investing in behavioral health (financial / cost, health, longevity, work quality etc) without sounding dismissive of the emotional benefits or individual responder experience. ie: having to ***"sell"*** something that is intrinsically beneficial is hard to do; there was an attempt to strike a balance with recommendations.

Challenge 3

Everything comes down to resources- both in terms of **people in roles**, and **money and time**. If you have enough of those, you can do whatever you want to do, but implementing any cultural change without them is difficult at best. The challenges faced by many departments in having to juggle choices and distribution of resources is acknowledged; it's real and it's very hard. Part of the hope in advocating for more discussion and consultation between departments is that leadership will be able to share ideas and suggestions with each other on how best to navigate these tough choices and decision points.

Background & Introduction

More firefighters die by suicide than in the line of duty[7], and telecommunications and EMTS / Paramedics are also at significant risk due to trauma exposure[8]. First responders also report more frequent suicidal thoughts and a higher readiness to act on those thoughts compared to the general population, due in part to their access to lethal means and acquired capability for suicide. These realities underscore not only a personal health crisis for first responders but also a public health issue that impacts families, communities, and the efficacy of emergency services.

The nature of response work involves repeated exposure to high-stress and traumatic events. This consistent exposure has led to elevated rates of psychological distress, including Posttraumatic Stress Disorder (PTSD), depression, anxiety, and suicidality. Studies estimate that 17–22% of firefighters suffer from PTSD[9], while 12–27% experience significant depressive symptoms following disaster response[10], and all responders are at high risk for mental health disorders and suicide. Despite the severity of these concerns, mental health resources within many first responder departments remain inadequate, partially developed, or underutilized. Stigma, organizational barriers, a cultural emphasis on toughness and a lack of understanding about normal human neurological response to crisis all also may contribute to widespread underuse of behavioral health services. Another issue that may contribute is the fact that response work, by definition, is reactive; there is a problem, and people respond to help or fix it, and response organizations of all kinds have become experts at tackling issues using this process.

> ***When it comes to behavioral health, it sounds strange to 'take the emotion out of it' but a pro-active approach not only saves lives, but money too. Investing in this on the front end prevents the need for big-time resources on the back end- things like in-patient treatment, out-of-state support, loss of time on duty and medical leave.***

[7] Streeb, Nicole Streeb, Kotaro Shoji, and Charles C. Benight. 2018. *"The Capacity for Suicide in Firefighters."* Suicide and Life-Threatening Behavior 49, no. 4 (August): 980-995. https://doi.org/10.1111/sltb.12500.

[8] Carson, L.M., Marsh, S. M., Brown, M. M., Elkins, K.L, & Hope M. Tiesman, H. M. (2023). An analysis of suicides among first responders - Findings from the National Violent Death Reporting System, 2015–2017,Journal of Safety Research,85, p. 361-370, ISSN 0022-4375, https://doi.org/10.1016/j.jsr.2023.04.003.

[9] Klimley, Kristin E., Vincent B. Van. Hasselt, and Ashley M. Stripling. 2018. *"Posttraumatic stress disorder in police, firefighters, and emergency dispatchers."* Aggression and Violent Behavior 43 (November-December): 33-44. https://doi.org/10.1016/j.avb.2018.08.005.

[10] Gulliver et al., 2015. *"Project Reach Out: A Training Program to Increase Behavioral Health Utilization Among Professional Firefighters."* American Psychological Association. https://psycnet.apa.org/ncript/2015-42702-001.pdf.

Risk Factors

The scope of first responder responsibilities has expanded over time. Firefighters, for example, now engage in a wide array of emergency services, including rescues, medical interventions, and disaster response; each bringing frequent exposure to trauma[11]. These repeated exposures, often referred to as regular exposure to trauma (RET), have made behavioral health concerns like PTSD, depression, and substance use increasingly common. Fire and EMS personnel report significantly higher levels of depression compared to the general population[12]. Certain predictors, such as PTSD and emotional exhaustion, also significantly increase the risk for mental health disorders and suicidality among first responders. For example, PTSD symptom severity, as measured by PCL-5 scores, predicts suicidality, with firefighters and law enforcement officers facing 1.05 to 1.06 times greater odds of suicidal thoughts or behaviors than the general public[13]. Emotional exhaustion, when left unaddressed, also impairs safety behaviors and overall well-being[14]. Researchers[15] further explain that suicidal behavior is strongly associated with a sense of burdensomeness, lack of belonging, and an acquired capability for suicide; all of which are common feelings among overworked and under-supported responders.

Culturally Appropriate Support

While awareness of first responder mental health has grown, existing supports are often reactive, inconsistent, or not culturally tailored. Traditional models such as Critical Incident Stress Debriefing & Critical Incident Stress Management (CISD / CISM) have shown limited and inconsistent long-term efficacy[16]. Peer-based programs like Project Reach Out, which train first responders to recognize and refer colleagues for counseling, are emerging as more relevant and effective alternatives[17]. However, such programs are not yet widespread, and behavioral health remains one of the most under-addressed issues in departments nationwide[18]. In King County as a region, data are lacking on behavioral health outcomes for first responders, generally.

Addressing these mental health challenges effectively requires a proactive, integrated plan that spans prevention, early intervention, treatment, and long-term support with perennial resources. Organizations must prioritize not just psychological interventions, but also the development of a positive safety climate that reduces emotional burnout and supports help-seeking behaviors[19]. **This includes increasing access to culturally competent providers and building networks of care that align with the values and experiences of first responders**[20] [21].

[11] Gulliver et al., “Project Reach Out”.

[12] Jahnke et al., 2023. “Evaluation of the Implementation of the NFFF Stress First Aid Intervention in Career Fire Departments: A Cluster Randomized Controlled Trial.” Int. J. Environ. Res. Public Health 20, no. 22 (November). https://doi.org/10.3390/ijerph20227067

[13] Beauchamp, Alaina M., Warren N. Ponder, and Katelyn K. Jetelina. 2023. “Dissecting the Interrelations of Suicidality and Mental Health Across First Responder Subtypes Seeking Treatment: A Cross-Sectional Study.” Journal of Social, Behavioral and Health Sciences 17 (1): 30-44. https://doi.org/10.5590/JSBHS.2023.17.1.04.

[14] Lee et al., First Responder’s Wellbeing, 209-231.

[15] Streeb et al., Capacity For Suicide, 980-995

[16] Bledsoe, B. E. (2003). Critical Incident Stress Management (CISM): Benefit or Risk for Emergency Services? Prehospital Emergency Care, 7(2), 272–279. https://doi.org/10.1080/10903120390936941

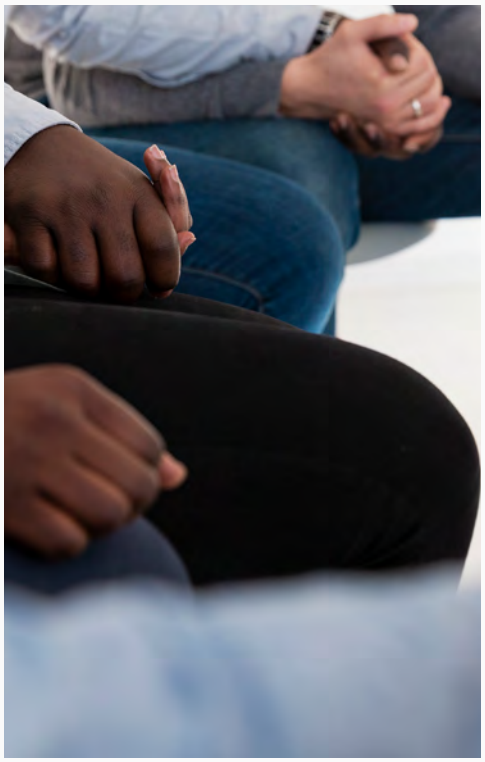
[17] Gulliver et al., “Project Reach Out”.

[18] Spell,, Firefighter Resources

[19] Lee et al., First Responder’s Wellbeing, 209-231.

[20] Jahnke et al., NFFF

[21] SAMHSA, MHAT, 1-16



Key Elements & Managing Complex Change

The need for consistent, evidence-based, cost-effective and efficient behavioral health programming and support for first responders is clear. While there are many pathways that can contribute to the goal of a healthier responder workforce, there are a few key elements related to lasting culture change that should be considered when any organization is moving towards a big developmental growth point. Regardless of sector, elements of lasting organizational change typically include **Training, Materials & Process, Operational Norms, Discussion & Consultation and Evaluation & Revision.**

In the context of behavioral health, these change ingredients represent an ongoing, interconnected and fluid process that shifts with changing needs, resources and goals, but it is important that all elements are included to some degree for a program, department or agency to achieve true success in long-lasting cultural change. The chart below describes each Key Element and the way that it can be engaged.

KEY ELEMENTS

#1 Training

Ongoing, formalized, and consistent training that is consistent with and supports best-practices in behavioral health and wellness. Should also include leadership orientation around culture change processes, leadership styles and communication, and foundational Mental Health Psychoeducation.

#2 Materials & Processes

Revision or adoption of training materials, manuals, required continuing education, and other programatic offerings from first career entry through retirement phases that include and emphasize behavioral health where appropriate.

#3 Operational Norms

Behavioral health becomes imbedded into operational processes, post-call debriefings; it is “just what we do here”. All responders learn how to recognize signs and symptoms of concerns in self and others and there is a positive incentive culture around pro-active coping from academy to retirement.

#4 Discussion / Consultation

Discussion and consultation occurs across and between districts of various sizes, on a regularly scheduled basis with a core leadership team and / or BH ‘rep’ group that has regularly scheduled huddles or the establishment of a learning community where challenges, successes and training opportunities are shared.

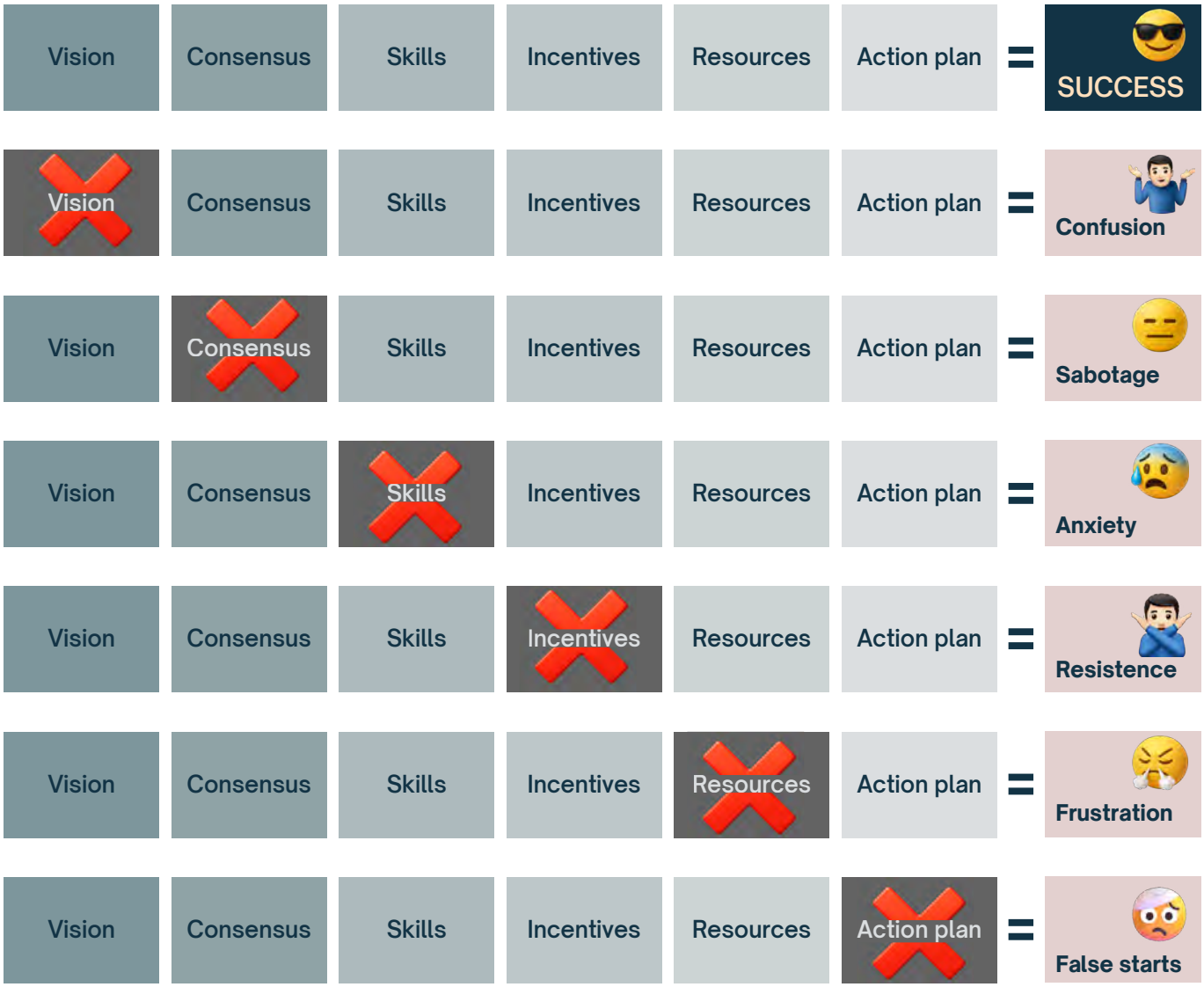
#5 Evaluation & Revision

Baseline data are collected on resilience and other desired outcomes and then repeated at interval. BH programming is evaluated for effectiveness at defined markers based on clearly measurable outcomes (ie good health, not just absence of bad health).

In addition to these key elements for positive behavioral health culture change, there is a model that may be relevant for leaders who are experiencing one or more of the common challenges when it comes to managing through complex change. The development of a robust and effective behavioral health program is certainly a complex and challenging process; this model is included to validate the typical roadblocks and highlight the key features related to a successful outcome. If you are working through the suggestions in the roadmap and encounter any of the outcomes that are alternative to “success”, you may be able to easily identify the aspect of the change process that is missing or insufficient[22].

[22] Adelman-Mullally, T., Sandy Nielsen, S., Seon Yoon Chung, S., Y.. (2023) Planned change in modern hierarchical organizations: A three-step model, Journal of Professional Nursing, Volume 46, p. 1-6, ISSN 8755-7223, https://doi.org/10.1016/j.profnurs.2023.02.002.

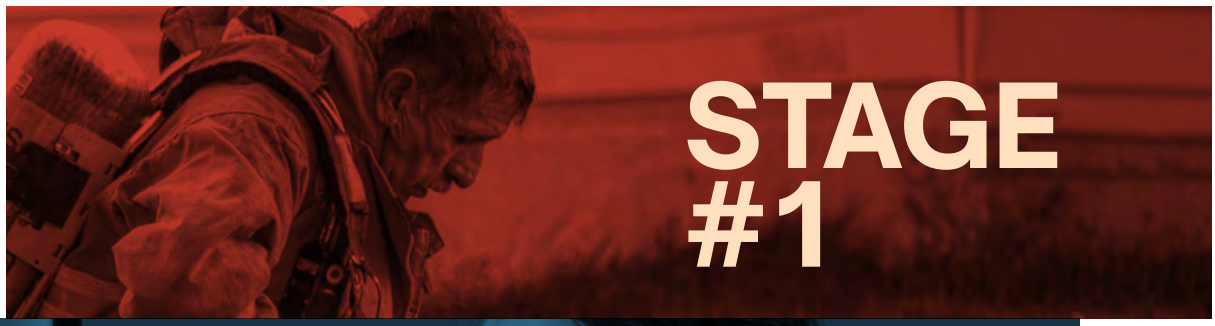
Managing Complex Changechange



The Lippitt-Knoster Model for Managing Complex Change

Summary

The roadmap found here outlines and describes the urgent need for culturally relevant and comprehensive behavioral health support systems for first responders in our region. It provides regionally contextualized steps and ideas, organized into distinct stages that reflect both the progression of mental health needs and the organizational responses and elements required to address them. By examining the current challenges and existing support structures, we aim to present actionable steps toward implementing and strengthening mental health care in first responder communities.


STAGE
#1


STAGE
#2


STAGE
#3

STAGE
#4


STAGE
#5


STAGE
#6

STAGE #1

DESCRIPTION

At stage 1, behavioral health is mostly a concept, and not something that has been operationalized in terms of either focus or funding. This roadmap may be able to help with that. While it may be recognized by some within your department that behavioral health is important, and the effects of trauma are sometimes observable, this isn't yet something that has been officially prioritized in terms of time or resources, or the opportunities to do so may have been missing. In this stage there is not likely to be a peer support ***"program"*** of any kind in place, and there may or may not be anyone officially trained in a peer-support role. Here are some additional indicators your department may be in Stage 1.

INDICATORS

- There may be recognition that behavioral health is an issue, but formal training or programming has yet to be developed or resourced.
- Peer-support is informal and there may or may not be an officially trained person in this role; may or may not have a peer-support lead.
- Behavioral health issues, when they come up for individuals on or off shift, may not often be addressed directly, or there may not be a specific process in place through which to handle things outside of the general ***"there should be a debrief"*** idea.
- The department doesn't yet include training on wellness or resilience as part of its annual requirements or programming, or behavioral health training, when offered, is usually viewed as a ***"bandaid"*** or a ***"hoop to jump through"*** rather than as a solution or part of a proactive bigger picture outcome.
- There is awareness of a need to address career phase-related behavioral health challenges (early, middle or late career), but no programming in place.

KEY FEATURES & EXAMPLES FOR STAGE 1

Lack of Defined Behavioral Health Culture

Mental health is not yet a strong part of department culture, only ***"coming into conversation"*** in the last several years. While peer support may exist, it is underdeveloped or informal, with limited structure and training. There may be ***"a guy"*** (or gal) who is the peer supporter in the department - but when they aren't on shift you are out of luck. Behavioral health discussions are not normalized ***"around the table"***, and there may be little cultural acknowledgment of its importance.

Resilience Training Is Absent or Undervalued

It was noted in several focus groups that both physical and mental aspects of resilience need to be trained and integrated across the career spectrum and range. In stage 1 and 2, these practices are rarely formalized or emphasized.

Behavioral Health Support is Reactive rather than Proactive

In Stage 1, the behavioral health 'process' is reactive in response to crisis, rather than preparing responders with preventative tools. Debriefings after critical incidents may be inconsistent, and there's often not a protocol to ensure ongoing follow-up. For individual peer supporters, where they exist, they indicated that they do not feel properly trained in how to care for their own mental health after responding to an incident and caring for others.

Limited Access to External Resources

The department may lack links to or easy referral information for culturally competent therapists, and struggle with high call volume, which reduces time for behavioral health training. There's minimal or no incentive to pursue additional mental health education or peer support roles; when this is done it's pursued ***"on your own time"***. There is an expressed need for paid (or time in service) related training that includes biological education on trauma. Access to a liaison counselor was named as a specific request to bridge current gaps.

ADVANCING FROM STAGE 1 to STAGE 2

Moving to the next stage helps to support first responders across all levels and places in their career; from new recruits or brand new firefighters going through academy, to those looking towards retirement and leaving the community they have identified with for the majority of their working life. It may seem difficult to get this behavioral health "ball rolling" but one key thing to keep in mind is that if it feels too big to start, it just means the first step isn't small enough. Here are some small(er) first steps for advancing to Stage 2.

- **Begin to embed long-term resilience or other behavioral health training alongside existing continuing education.** It is clear there are a LOT of existing requirements for ongoing training, so this is already often a scheduling challenge, but this isn't an 8-hour day training four times a year- it can be as simple as including 15 minutes in an hour-long training on other kinds of health or wellness, where both physical and mental resilience can begin to be viewed (and treated) as interconnected.
    - Elements of change model

TRAINING **OPERATIONAL NORMS**

- **Prioritize developing partnerships with similar or like-minded departments in order to share information and resources on behavioral health support.** This can include identifying and co-training peer support team members or formalizing peer-support agreements between departments so that they remain consistent over time.
    - Elements of change model

DISCUSSION & CONSULTATION

- **Identify ways to develop and structure a peer-support program for the long term.** Some important questions to ask and answer for this step: Who would be the lead? How can this program be incentivized and supported in the long-run? What long-term resources can be identified? How can new peer support members be recruited and trained? Peer support programs that are successful in the long-run usually include some sort of resource allocation or incentive and more than one person in the department who is actively engaged in the work. (The First Responder Center for Excellence recommends 10% of the department as a good start for a peer-support team and we recognize that 10% may in some cases be 2 or 3 people total).
    - Elements of change model

TRAINING **MATERIALS & PROCESSES**

OPERATIONAL NORMS

STAGE #2

DESCRIPTION

In Stage 2, the department may openly recognize and discuss the need for behavioral health programming, training and support, but there is not yet a program or system in place for making that happen. Peer-support may be implemented or partially implemented (eg: there's someone sometimes on a shift who did the peer-support training a while ago), but training is not formal or consistent, and there isn't any continuing education for peer support members or leads. Behavioral health education is largely absent from other formal, annual training requirements, and external referral resources are inconsistent, word-of-mouth, or hard to access.

INDICATORS

- Peer-Support program exists, but it is underdeveloped, inconsistent or informal.
- Behavioral health services are not available in-house, and external services may be underutilized and lack visibility, and/or trust, or there are significant access challenges.
- The department is open to discussing behavioral health additions or changes but may not know where to start.
- No resources have yet been allocated towards behavioral health programming, training, etc
- There is no or very little programming related to career phase specific challenges (early, middle, late).

KEY FEATURES & EXAMPLES FOR STAGE 2

Potential Consequences Related to Lack of Behavioral Health Support

A department in stage 2 may experience significant difficulty accessing culturally competent therapists and long wait times for appointments; when this is coupled with an underdeveloped peer-support program in-house, there may be evidence of higher stress levels, more sick days being used, more long term medical leave, and higher turnover or early retirement in some cases.

Minimal Support after Incidents

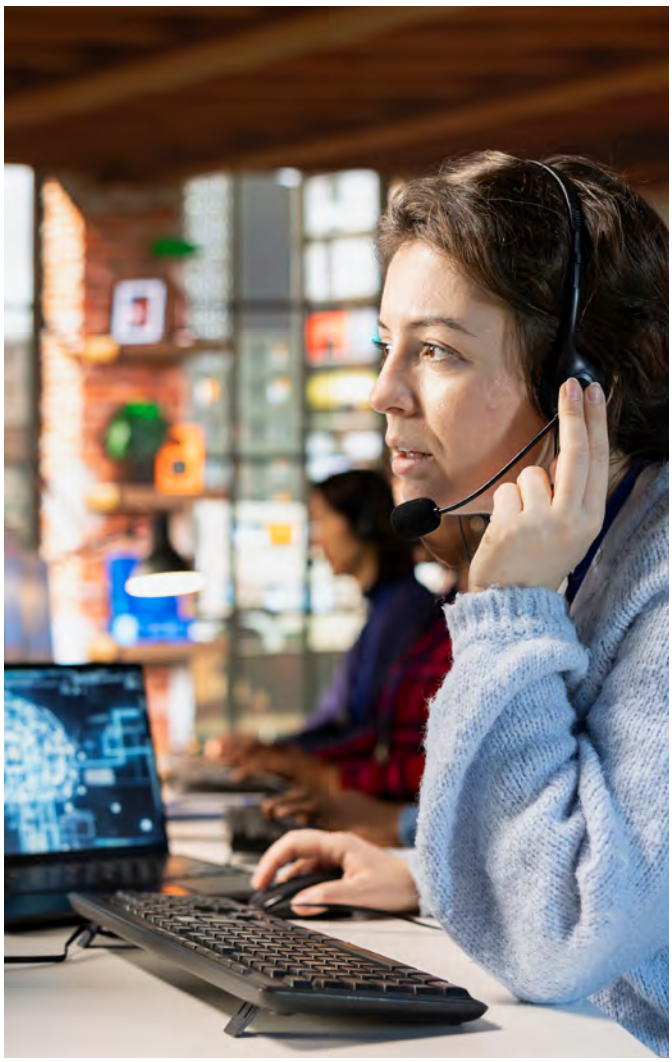
If there are one or two peer-support personnel, they may not have sufficient training or support themselves and may feel ***"out of their depth"*** depending on the type of incident that needs support. In addition, there may just not be enough time or training to follow processes that are in place. One peer support member commented: ***"Technically there is a formal process that is just not followed. Peer-support responders take it upon themselves to check in post-event. You get 30 minutes before running to more calls if you get it... It's up to the officers deciding the break or length of the break".***

Trainings Offered are Lacking or Repetitive

One barrier that was mentioned in Stage 2 was a lack of access to effective, helpful and appropriate training, for peer-supporters and others. There may be terminology or topics of interest (such as secondary traumatic stress), but they are not included or emphasized. Some web-based trainings are ***"dry, boring and repetitive"***, rather than engaging.

Cultural Gaps and Isolation

Some responders in Stage 2 reported feeling excluded or disconnected from others within the department, but also expressed a need for interdepartmental collaboration to be more available. This is particularly relevant for smaller departments in the region who may not have access to multiple types of support or trainings. Regular interactive events and structured opportunities to build culture and support were described as ways to improve the community feel, but this felt logistically ***'out of reach'*** due to ongoing staffing and scheduling challenges.



ADVANCING FROM STAGE 2 to STAGE 3

Moving to Stage 3 necessitates the early program development of a peer-support process for the long term that is embedded within the responder experience from the time they join the department until they retire. A robust peer-support program is the cornerstone for a solid behavioral health program and essential for cultural change in that direction. This isn't just about having a ***"few people"*** who are peer supporters, but formalizing a selection, intake, training and continuing education process for all peer-supporters and leads.

To advance to Stage 3:

- Formalize a structured peer-support training and continuing-education process whereby ALL peer supporters and leads are expected to complete the same initial training like this one or similar others, and also have bi-annual(quarterly is ideal) ongoing continuing education on new strategies, information and interventions. To increase compliance, consistency and participation, being a peer-supporter is, ideally, also backed by resources or incentives so that these trainings are not completed on the responders **"free" or "off time".**

TRAINING **MATERIALS & PROCESSES**

OPERATIONAL NORMS

- Identify or allocate funding resources specifically to promote behavioral health and wellness. It doesn't have to be much, but it does need to be earmarked specifically for this purpose to seriously contribute to culture change that supports health. This funding could take the form of a designated peer-support lead (shift time), a part time clinician who can begin to establish a relationship with the department, additional high-quality training opportunities, PTO or sabbaticals.

MATERIALS & PROCESSES

- Consider programming that is specifically oriented to early, middle or late career stage interests. There are dramatically different behavioral health emphases at each career point for responders, and when it comes to health, identity, support and wellness, different tools and strategies are needed. This programming can be offered in collaboration with other departments as well.

DISCUSSION & CONSULTATION

STAGE #3

DESCRIPTION

At stage 3, there is observable consistency with behavioral health **program development** within the department. Things are ***"happening"*** and leaders are talking about it. This may include a peer support training program that is being consistently worked on, improved, and formalized or structured. Post-call check-ins are becoming more routine. Norms are shifting so that behavioral health is something that is included in other more general health-related training and discussions; there is clear linkage between mental wellness and issues like sleep, nutrition and substance use. There is a realization across the department that care, both physical and mental, needs to be collective. Some efforts have been made to develop relationships between departments, share training resources on this topic, or collaborate on programming that supports wellness throughout the ***"life cycle"*** of a responder.

INDICATORS

- Departments are navigating structure, capacity and balance when it comes to consistent training and formalization of behavioral health programming (including peer support), and leadership has ***"bought in"*** to the necessity of prioritizing these issues.
- There are conversations happening between department peer supporters or leadership (either to collaborate on training, share resources, or to learn from others about what has worked and what hasn't to sustain behavioral health support).
- Resources (time and funding) have been identified for use for this purpose, even if they haven't been allocated yet.
- Relationships with community providers and external therapeutic supporters are being curated.
- Leadership is trained on and aware of career-phase specific behavioral health challenges.

KEY FEATURES & EXAMPLES FOR STAGE 3

Awareness Transforming into Action

Awareness is now present in terms of the importance of behavioral health, but stigma is still a significant roadblock when it comes to practical issues of implementation. There may still be a lack of collective agreement as to the benefits of peer support, especially among some later career responders. Thinking creatively about how to incentivise participation in peer-support may be a necessary next step. Reinforcers can vary and can also change over time based on what is needed and valued, and what resources are even available to the department.

Resource Support

Funding is being identified. Once the realization of the benefits to BOTH personnel and the "bottom line" become clear, funding is identified to be allocated to behavioral health programming. This could include the potential for contracting with a community provider or clinic on a part-time or shared-schedule basis with another department to work in house with the department and begin to develop those relationships that enable trust. Resource support may also be used to increase the frequency and quality of training for peer supporters and leads, or to incentivize participation in that program.

Cultural Norms are Shifting

The awareness of the importance of behavioral health support and programming has begun to create a slow but steady shift of interest and attention throughout the department. Career-phase specific programming can play a very important role in this. If people can buy into the concepts based on what is real, relevant and in front of them RIGHT NOW based on what they are seeing and experiencing then they will be much more likely to actively participate, talk about it and engage in best-practices. For early career responders this may mean some group discussions about adjusting to the schedule or demands of the work; for mid-career this may mean sharing information about active coping and what helps with repeated trauma and secondary trauma exposure; for late-career, this may include groups on identity outside of the work, post-retirement connections and other aspects of long-term resilience.

ADVANCING FROM STAGE 3 to STAGE 4

Advancing to the next stage in behavioral health and wellness for your department requires solid ***"top-down"*** support for cultural change. Many departments may plateau in their progress here as making the next step requires significant investment in terms of both time and resources. This is ***"walking the talk"***; not just lip service for wellness but **concrete resource allocation for program development,** the maintenance and improvement of a consistent peer-support team, and the early stages of evaluation to determine logical next steps. It's impossible to figure out where to do if it's not clear what you are doing well, or doing poorly. This stage in the roadmap requires some evaluative check-ins to make sure things are on the right track, or to realign priorities so that things keep moving in the direction you want to go. This is a good time to consider the Lippet-Knoser model for managing complex change; you may be running into some roadblocks with implementation here, and the kinds of roadblocks you experience can give you a lot of insight into what missing pieces may be needed in order to move forward.

- **Evaluate gaps in the way the program is developing.** Do you have training now, but there are still NOT ENOUGH external therapists or culturally competent providers to act as referral resources? What training do you offer in general that includes elements of behavioral health, and is it high-quality or what is needed? (See Appendix B for ideas)

EVALUATION & REVISION

- **Consult with other leaders and departments to increase resource and idea sharing.** Maybe there is a new app out that someone is using and it's very helpful; maybe a new clinic opened up that specializes in support for first-responders, or there is a new online training available that is great. This may be the time to start a regularly scheduled meeting (bi-annually or quarterly) to check in, share ideas about what programming options are out there that you can share and learn about.

DISCUSSION & CONSULTATION

MATERIALS & PROCESSES

- **Programs, groups or training that is oriented towards career-stage is being vetted and improved.** Now is the time to add in or replace out-of-date trainings to create career stage-related offerings. This need was voiced in EVERY focus group as a significant missing contributor to wellness. In order to advance to stage 4, this programming needs to be developed and / or improved, and offered on a continual and rotating basis.

MATERIALS & PROCESSES

EVALUATION & REVISION

STAGE #4

DESCRIPTION

At stage 4 functional and visible behavioral health programs are underway within the department, and there is some ongoing review or assessment of efficacy and utility. Some cultural, logistical or communicational barriers may still be present in terms of the flow from the experience of an incident to peer support, to external referrals as needed, but there is clear advocacy for learning and improvement based on any identified behavioral health needs. **Cultural norms have shifted to include language around behavioral health and wellness.** Importantly, behavioral health terminology and training opportunities are present ***"from the get go"*** for new or early career responders and are broadly accepted as part of the health and wellness generally, even if not everyone participates in using peer support or other resources. Peer supporters in this stage are well trained, and participate in ongoing, **incentivized and required continuing education** based on the constantly evolving research outcomes for responders found in psychology, neuroscience, medicine and public health.

INDICATORS

- Peer supporters are active, well-trained, and available on a regular basis. **There may not be a lead or peer supporter on every shift depending on the size of the department,** but access protocol is commonly understood and clear.
- Peer support teams are working to create more visibility and integration into the department as a whole.
- Department leadership openly acknowledges mental health risks inherent in response work (e.g. burnout, trauma, identity loss, stigma) through internal communications. This could include making concrete proposals or changes to forms, manuals, etc that include requirements and recommendations consistent with the reality of the medical aspects of critical incident exposures.
- There is thoughtful training or programming provided that is intentionally specific around "career phase". This could include interdepartmental meetings, activities, trainings or other supports that are intentionally for early, mid or late-career responders.
- Collaboration with other departments on regional training opportunities or resource sharing in behavioral health is in development. The foundation for this indicator is established with early discussion and consultation in stages 2 and 3; once the relationships are present, they can become more developed. This doesn't need to be occurring on a large team or group level- it could start with leaders or peer-support leads meeting between departments.

KEY FEATURES & EXAMPLES FOR STAGE 4

Established infrastructure with gaps in utilization

Peer support uses IAFF training or similar others for consistency and formality, and the systems are in place to encourage active participation. Some peer support members may report being underutilized or unclear as to how to be ***'useful'*** and may not be proficient on exactly how to access available resources.

Cultural momentum toward earlier, proactive support

Leadership has begun to encourage early connections to behavioral health professionals before crises arise. This shift points to cultural change in understanding (and opening talking about) the benefits of behavioral health programs that are available. Support is growing for connecting members of the department with professionals before they are in need of one, promoting proactive support for the department.

Leadership strain and limitations

Leadership and those in peer support roles wear many hats, where captains may cover peer support, hazmat, and union roles (and more!). Resources may not have not yet been allocated to compensate for this level of balancing and juggling roles, which can decrease the ability for those in peer support roles to have the ability to attend new trainings (continuing education) on top of their other responsibilities.

Emphasis on transitional and identity-related risks

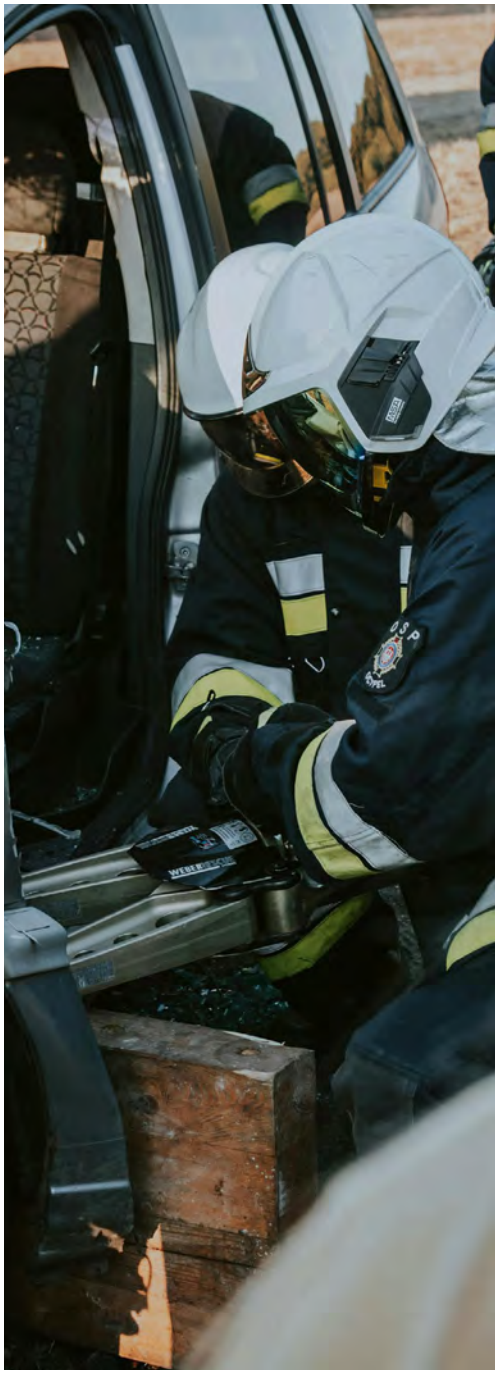
The need for behavioral health resources at different points of the career timeline, especially in relation to the time period around retirement is widely accepted. Recognition of the difficulty many responders have in finding identity after retirement promotes allocating resources for increased support in this time period. There's a call for gradual offboarding and ongoing connection to community.

Rapid development but inconsistent normalization

Peer support is making rapid development, but this can be without the structural integrity around it to promote rapid integration. Trainings may not have fully prepared members with the information or steps they need to take to proactively reach out to people in crisis. At the same time, peer support is culturally shifting to being viewed as essential.

ADVANCING FROM STAGE 4 to STAGE 5

Advancing from stage 4 to stage 5 requires that mental wellness and behavioral health support and processes become normalized. Behavioral health training is seen as essential rather than an optional resource. Peer support members are available across shifts and trust is being built so that they are utilized and there is growing familiarity with their role. There is an effort to create a long-term (contractual) relationship with a therapist or clinic such that someone is either a) available as a priority resource in the community and there is familiarity with that person and their level of competence, or b) available on site on a part time or rotating basis so that they become familiar with the responders on various shifts. Hiring or contracting culturally competent therapists with sustained involvement and visibility within the department will help promote mental wellness within the department as well as mitigating the consequences of ***"trying out"*** behavioral health professionals without vetted or known cultural competence.



- **Development of shared regional wellness hubs.** Collaboration with surrounding departments to promote the introduction of regional behavioral health and mental wellness resources can lessen the burden on departments of different sizes and geographic locations. It can be difficult to be solely responsible for allocating enough resources for behavioral health help, so collaboration can benefit not only monetary resources, but build connection between departments working within the same region who may not otherwise be in regular communication.

  DISCUSSION & CONSULTATION

  MATERIALS & PROCESSES

- **Introduction of behavioral health trainings or wellness support within on-duty hours.** Implementing behavioral health trainings into a scheduled on-duty time can help to normalize and integrate the tools of behavioral health into daily life. Promoting these services can also introduce career-long behavioral health planning, particularly including during retirement and role transitions throughout the career. Other examples include incentivized participation in exercice or physical work-outs to support health generally.

  MATERIALS & PROCESSES

  OPERATIONAL NORMS

- **Structured decompression procedures and appropriate follow-ups.** Providing set decompression procedures following a critical incident can mitigate information overload and allow time for those involved to have time to process the event that took place. In addition, ensuring systemic continuity and follow-up after any initial peer support engagement provides the ability to build up trust and repertoire with peer support members and first responders.

  OPERATIONAL NORMS

STAGE #5

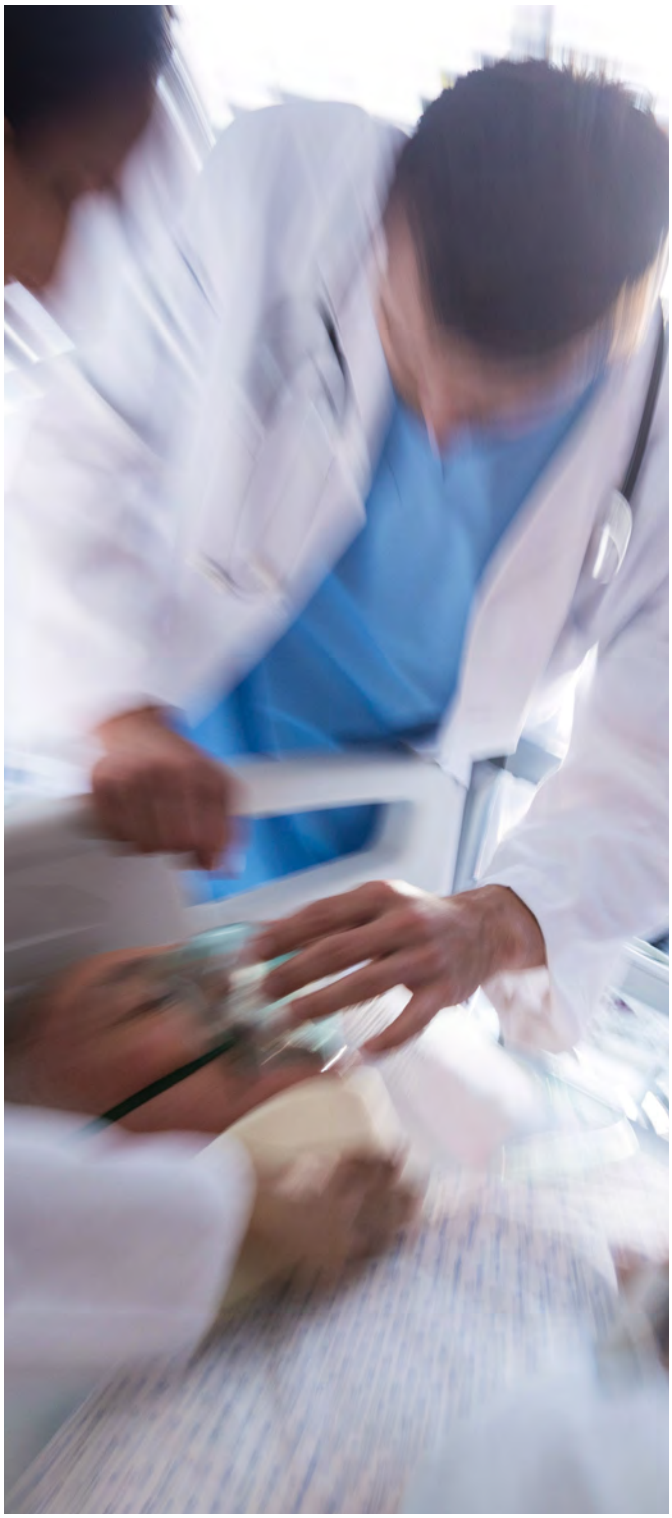
DESCRIPTION

A department at stage 5 is able to recognize and understand that different approaches are necessary in uniquely supporting every individual with behavioral health. Those in leadership roles as well as all others in the department are aware of the resources they have available, and utilize them when appropriate. Interventions, when necessary, are usually implemented. There is also a generally accepted understanding of things like secondary traumatic stress and resilience (both practically and conceptually). Training materials have been updated to include language consistent with behavioral health and wellness; it is no longer an *'add on'* but part of medical, health and training in general.

INDICATORS

- Behavioral Health and support is culturally appropriate and normalized. Mental wellness has begun to be integrated into trainings, from rookie year- forward.
- Peer support processes are triggered after critical incidents occur as a matter of course and after that initial contact, further check-ins happen as needed on a regular basis.
- There is positive reinforcement (incentive) for participation in sponsored activities (like workouts) that are known to have mental and physical benefits.
- Success may not yet be measurable, but visible changes are occurring in relation to mental health and there is consistent reflection that people are feeling ***"better"*** (better sleep, better active coping habits etc) and this beginning to be reflected in medical leave data. Collaboration with other departments is under way such as with the sharing of resources and other support.

KEY FEATURES & EXAMPLES FOR STAGE 5



Behavioral Health Normalization

Conversations around behavioral health are being integrated into the day-to-day functioning of the department. The benefits of mental wellness and the routes to maintain it are shared at the recruitment and academy level. While impacts may not yet be measurable, the cultural shift is present. ***"..This is part of the cultural shift. If we are introduced to this in the Academy at that level, it may not have an impact then but it's like a sponge. We are starting to soak that up and make it normal, which is that cultural shift..."***

Regular Trainings

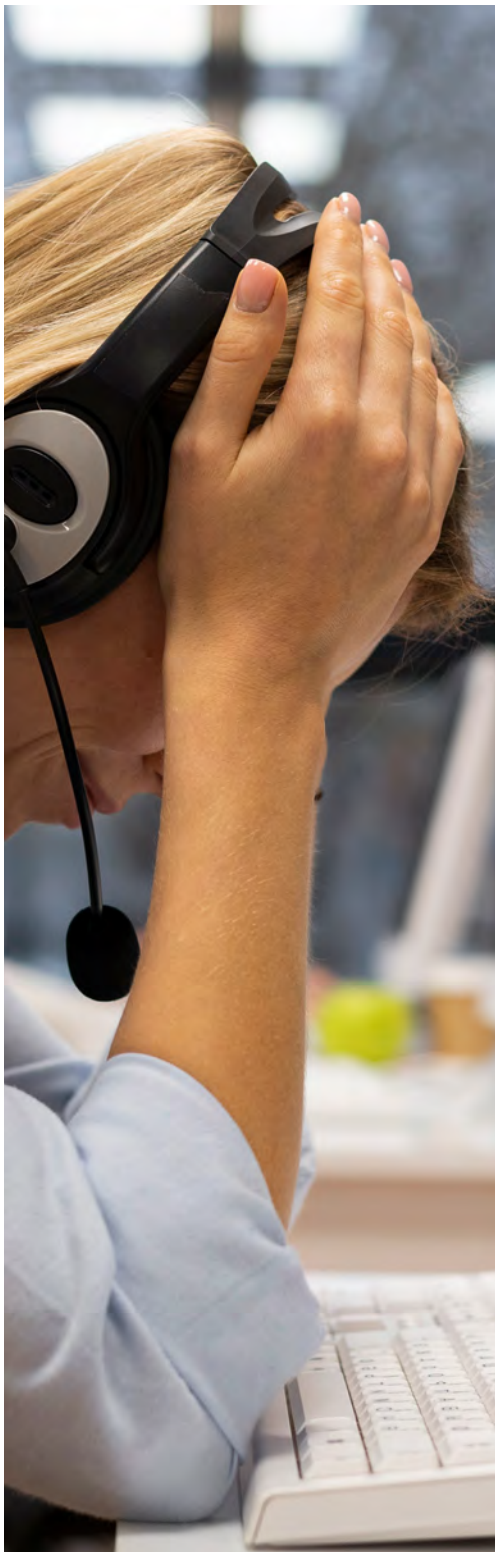
For the first time, integrated, regular behavioral health trainings are underway and gaining success. For example, ***"There's quarterly department-wide training that includes a mental health component, and it ties into what the peer support team is doing."***

Exposure to Impacts

Internal training on the impacts of second-hand trauma are happening. ***"We've done internal training on how to have tough conversations"***. There is also more integration of the impacts of the job mentally for the department. ***"Six weeks into the class, we present on mental health in the —including physical and mental impacts."***

ADVANCING FROM STAGE 5 to STAGE 6

Advancing to the last stage of the six-stage behavioral health structure requires the department to fully incorporate behavioral health practices into all aspects of operations. More perennial resources are being allocated to behavioral health services, and there is increased transparency about the resources available to all personnel. There is routine seeking of feedback from staff at all levels about potential improvements, and feedback is valued and promotes change.



- **From Awareness to Cultural Ownership.** Moving from Stage 5 to stage 6 requires fully embedding behavioral health aspects into department operations, leadership values, and identity. In other words, behavioral health is no longer just a part of training and response, but also found in the department overall, from the top down.

OPERATIONAL NORMS

MATERIALS & PROCESSES

- **Development of Clear Outcome Measures.** As behavioral health practices increase and become incorporated into the department, there are also more outcome measures that can be observed and measured. Improvements in sleep, higher job retention, and heightened trust in peer support members may be apparent.

EVALUATION & REVISION

- **Leadership Training.** Leadership is trained in developing behavioral health needs and practices, and empowered to continually train the rest of the department. Professional development now includes state-of-the-science behavioral health information.

TRAINING

- **Integration of Behavioral Health Professionals.** There is an appointment of on-site behavioral health professional(s) (contracted externally or in-house) for the department on at least a part-time basis. A consistent routine of behavioral health services continually develops to support all personnel.

OPERATIONAL NORMS

STAGE #6

DESCRIPTION

At stage 6, behavioral health is fully integrated and culturally embedded throughout all levels of organization. It is recognized as a core value in response work that is proactively utilized through peer support programs, mental health practices, and wellness initiatives. This is visible and utilized in daily operations, policies, and organizational culture. Leaders are properly trained and actively assessing and tailoring departmental needs with training and support. These resources are fully accessible and well-received through consistent engagement and sustainability.

INDICATORS

- Department leaders maintain collaboration regionally, consulting with less-resourced departments.
- Mental health resources like peer-support or therapeutic services (on or off site) are consistent and actively utilized by many members of the team.
- Members of the department self-initiate behavioral health care PROACTIVELY as it is seen as a strength not a weakness.
- Behavioral health training is embedded into shift-duties to support work-life balance for all members.
- Behavioral health outcomes are trending positively.
- Leaders are proactively assessing best practices during post-incident responses.

Keep an eye out for

- Complacency or loss of urgency around behavioral health needs.
- Temporary peer support burnout due to lack of support or recognition.

KEY FEATURES & EXAMPLES FOR STAGE 6

Consistent Behavioral Health Resources

Behavioral health resources need to be ***"authentic, which means constantly committing, moving forward, and gradually adding to it, rather than all at once."*** There is also an emphasis on the strength it takes to reach out, and getting to a place of knowing there is more help, or what additional resources are needed.

On-site Mental Health Professional

"..because I am here it is easier to work with others on this. I am able to see who is working, check up on people once a month, etc. The feeling of people liking to work here is so high..I'm really impressed with the culture." Due to this, trust has developed between people in the department.

Consistent and Revised Professional Development

Professional development includes updated, engaging, and useful training on neuroscience, trauma, secondary traumatic stress, sleep, burnout, active coping and nervous system responses from internal professionals or external vendors.

Collaboration with nearby departments

Collaboration efforts with other departments to further promote behavioral health are thriving. ***".. there is no financial transaction. It's an agreement that they help us out and we help them."***The concept of having a regional behavioral health unit that is formally coordinated with the whole region is being discussed, where there would be jobs solely to coordinate and realize this strategically and tactically.

A PATHWAY FORWARD

- The department continues to advocate for further education to address evolving challenges that may come up.
- Leaders focus on maintaining behavioral health within the culture by continually evaluating and improving its programs best practices.
- Cultural humility is practiced as leadership routinely seeks feedback and adapts programing.

CAREER PHASE RELATED RECOMMENDATIONS




	ACADEMY & RECRUITMENT	EARLY CAREER	MID-CAREER	LATE CAREER
RELEVANT FOCUS OR ISSUES	Realistic perceptions of mental health challenges; developing healthy coping and resilience strategies right away	Balancing eagerness and energy with strategic coping and good boundaries	Long-term trauma exposures, cynicism and moral injury, burnout	Identity outside of unit or department; sense of purpose post-retirement
STRATEGIES AND IDEAS	Introduce behavioral health practices into the academy, with some emphasis on the realities of firefighting beyond the excitement and positive aspects of the job, to avoid false-framing of the toll firefighting can take	Introduce trainings relating to behavioral health that emphasize whole body health connections- the brain science behind what happens to people under long-term exposure to high-stress	Reinforce active coping, professional development around more advanced psychological concepts related to stress responses, vagal nerve connections (neuroscience) and resilience	Establish opportunities for mentorship or coaching for those earlier in the career journey; formalize a mentor check in system if needed to reinforce connections
TACTICS	Teach active coping skills and interventions; develop a personal coping plan	Reinforce active coping skills and stress reduction interventions; teach boundary setting and reinforcement	Professional development includes training on personal resilience: Purpose, Connection, Adaptability & Hope	Personal coping plan should be re-evaluated to include increases in sense of purpose-aligned activities outside of work

RESOURCES AND REFERENCES

RESOURCES

Tactical Stress Tools for Responders

Crisis Hotlines
King County Suicide Prevention
1-866-427-474

24/7 Support
King County Crisis Service
https://kingcounty.gov/en/dept/dchs/human-social-services/behavioral-health-recovery/crisis-services

TherapyTrauma focused therapists in King County
https://www.psychologytoday.com/us/therapists/wa/king-county?category=trauma-focused

Peer Support
Peer Support Training
https://www.iaff.org/peer-support/

Creating Peer Support Programs
https://healingourown.org/department-resources

Nutrition
Overview of the Importance of Nutrition
https://www.iaff.org/wp-content/uploads/Nutrition/FFNutritionGuide_v6.pdf

Sleep
Why sleep is important (APA)

Working Out (Layer of recovery through meditation like yoga and walks)
https://www.firefighternation.com/health-wellness/active-and-passive-recovery-for-the-functional-firefighter/

Information on Trauma
Working out to help Trauma
https://www.ticti.org/exercise/

Secondhand Trauma
Information on Secondhand Trauma

Resilience
Information on Resilience

Emotional Intelligence
Emotional Intelligence Information

Mental Health Apps

- **My Strength**
  https://mystrength.com/
- **Heroes Health**
  https://heroeshealth.unc.edu/
- **Cordico**
  https://cordico.com/fire-2/
- **Alli Connect**
  https://www.alliconnect.com/
- **CrewCare**
  https://crewcarebenefits.com/
- **The GUIDE App**
  https://theguideapp.com/
- **Lighthouse Health & Wellness**
  https://www.lighthousehw.org/
- **PowerLine**
  https://www.powerdms.com/power-line
- **PeerConnect**
  https://firstresponsemh.com/peerconnect/

Leaning in on Family and Community Support
WA 211
https://wa211.org/

NFFF
https://www.firehero.org/

NAMI
https://www.namiwa.org/familysupportgroup

Alcoholics Anonymous (AA) Greater Seattle
https://www.seattleaa.org/meetings/

Western Washington
https://area72aa.org/

Substance Abuse and Mental Health Services Administration (SAMHSA)
https://www.samhsa.gov/

Narcotics Anonymous (NAADAC) Seattle Area
https://seattlena.org/

NAADAC
https://www.naadac.org/

Seasonal Affective disorder treatment
Season Affective Disorder

Bright Light Therapy Lamps (Mood Boosting)
The Best Light Therapy Lamps for Beating the Winter Slump

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Ben Lane, Fire Chief, Eastside Fire

Kristin Cox, Behavioral Health Coordinator, Seattle Fire

Penelope Stone, Captain, Seattle Fire

Vonnie Mayer, Executive Director, Valley Com 911

Daniel Alexander, Deputy Chief, Renton Fire

John Gallup, Battalion Chief, Puget Sound Fire

Jim Whitney, Deputy Chief, Redmond Fire

Randy Krause, Fire Chief, Port of Seattle

As well as:

Brooke Lundquist, PhD, LMHC, Redmond/ Snohomish Fire

Evan VanOtten, Division Chief & Paramedic, King County Medic One

Christopher Brown, Deputy Fire Chief, Snoqualmie Fire

Mike Washington, MSW, MSgt USMC Ret, Seattle Fire Department Ret

Cory James, Fire Liaison Supervisor, NORCOM

Rob Groeschell, Firefighter A-shift, Port of Seattle

Dustin Trout, Deputy Fire Chief, Mtn View Fire

Bryce Kraft, Lieutenant, Mtn View Fire

Dawn Judkins, Fire Chief, Mtn View Fire

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Brad Thompson, Fire Chief/ Administrator, Valley Regional FIre Authority

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Thank you all for your vision, participation and commitment to this work


PUGET
FIRE
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KING 2


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VALLEY REGIONAL
RFA
FIRE AUTHORITY


MOUNTAIN VIEW FIRE & RESCUE
FIRE
M
RESCUE


BOTHELL
SC 10 ED
FIRE


FIRE
EASTSIDE
RESCUE


FIRE
SHORELINE
DEPT.


FIRE
KCFD
NORTHSHORE
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DEPT.


SKYKOMISH
KCFD #50
FIRE
RESCUE
FIRE DEPARTMENT


KIRKLAND
FIRE


MERCER ISLAND
FD
MI
FIRE


NORTH HIGHLINE
FIRE
RESCUE
FIRE DEPT.


CITY OF SEATAC
FIRE
RESCUE
FIRE DEPARTMENT


SNOQUALMIE
EST. 1903
FIRE
RESCUE


PUGET
SEAL OF TUKWILA WASHINGTON
1908
SOUND


VASHON ISLAND
1942
FIRE & RESCUE


FIRE DEPARTMENT
RESCUE·EMS
REDMOND


RENTON
REGIONAL FIRE AUTHORITY


TEAM CRAIG FIRE AND RESCUE GROUP INC. 2017


PACIFIC COUNTY
FIRE
EMS
FIRE DISTRICT 1


WOODINVILLE
FWR
FIRE & RESCUE


Valley
COMMUNICATIONS CENTER


911
NORCOM

APPENDIX A

Instructions: the number of items you check ***"YES"*** for will give you an indicator of the closest stage your department may be experiencing. It is likely that there will be overlap, and you may have more than a few boxes checked in each stage. The primary stage is whichever one feels like the best match based on the description in the roadmap, and the most actionable "next steps" for advancing to the next stage.

Behavioral Health and Wellness Self-assessment

STAGE 1

Yes Some No

There may be recognition that behavioral health is an issue, but formal training or programming has yet to be developed or resourced.

Peer-support is informal and there may or may not be an officially trained person in this role; may or may not have a peer-support lead.

Behavioral health issues, when they come up for individuals on or off shift, may not often be addressed directly.

The department doesn't yet include training on wellness or resilience as part of its annual requirements or programming.

There is awareness of a need to address career phase-related behavioral health challenges (early, middle or late career), but no programming in place.

STAGE 2

Yes Some No

Peer-Support program exists, but it is underdeveloped, inconsistent or informal.

Behavioral health services are not available in-house, and external services may be underutilized or have significant access challenges.

The department is open to discussing behavioral health additions or changes but may not know where to start.

No resources have yet been allocated towards behavioral health programming, training, etc

There is no or very little programming related to career phase specific challenges (early, middle or late career).

STAGE 3

Yes Some No

Departments are navigating structure, capacity and balance when it comes to consistent training and formalization of behavioral health programming.

Leadership has ***"bought in"*** to the necessity of prioritizing these issues.

There are conversations happening between peer supporters or leadership from other departments to collaborate and learn/ share ideas.

Resources (time and funding) have been identified for use in behavioral health programming, even if they haven't been allocated yet.

Relationships with community providers and external therapeutic supporters are being curated.

Leadership is trained on and aware of career-phase specific behavioral health challenges.

STAGE 4

Yes Some No

Peer supporters are active, well-trained, and available on a regular basis. There may not be a lead or peer supporter on every shift depending on the size of the department, but access protocol is commonly understood and clear.

Peer support teams are working to create more visibility and integration into the department as a whole.

Department leadership openly acknowledges mental health risks inherent in response work (e.g. burnout, trauma, identity loss, stigma) through internal communications.

There is thoughtful training or programming provided that is intentionally specific around ***"career phase"***.

Collaboration with other departments on regional training opportunities or resource sharing in behavioral health is in development- starting with leaders or peer-support leads meeting between departments.

STAGE 5

Yes Some No

Behavioral Health and support is culturally appropriate and normalized. Mental wellness has begun to be integrated into trainings, from rookie year- forward.

Peer support processes are triggered after critical incidents occur as a matter of course and after that initial contact, further check-ins happen as needed.

There is positive reinforcement (incentive) for participation in sponsored activities (like workouts) that are known to have mental and physical benefits.

Success may not yet be measurable, but visible changes are occurring in relation to mental health and there is consistent reflection that people are feeling “better”.

Collaboration with other departments is under way such as with the sharing of resources and other support.

STAGE 6

Yes Some No

Department leaders maintain collaboration regionally, consulting with less-resourced departments.

Mental health resources like peer-support or therapeutic services (on or off site) are consistent and actively utilized by many members of the team.

Members of the department self-initiate behavioral health care PROACTIVELY as it is seen as a strength not a weakness.

Behavioral health training is embedded into shift-duties to support work-life balance for all members.

Behavioral health outcomes are trending positively.

Leaders are proactively assessing best practices during post-incident responses.

APPENDIX B

Available Behavioral Health Training Options

Training and Workshops offered by Astrum Health LLC for responders - reach out to drkira@astrumhealthllc.org for more information:

1. Disasters and Critical Incidents: Best Practices in Behavioral Health

Behavioral health impacts from critical incidents, emergencies and large-scale disasters are often overshadowed by other types of community concerns during the recovery from the event, and often misunderstood by responding agencies as well as the community members who have experienced them. This training will explore some of the typical short- and long-term behavioral health challenges and outcomes related to disasters and provide evidence-based best practices for practical resilience-oriented community recovery. Current neuroscience and clinical techniques will be discussed in the context of practices which enhance recovery-oriented communication, de-escalation, and active resilience building supports for children, youth, and adults. Learning Objectives):

- Behavioral health considerations related to the phases of large-scale disaster recovery
- Information about the physical and neuro-chemical processes at work when we transition in and out of from ***"emergency"*** mode
- Communication and intervention basics in Disaster Behavioral Health
- Strategies for working in this area of specialty, and considerations for home and professional preparedness
- Operationalizing resilience in accessible and concrete ways

2. General Workplace Resilience Presentation (50-60 minutes).

This presentation provides updates on current issues in behavioral health from the perspective of recovery from emergencies and local critical incidents. With a focus on typical neurological and physical experiences and the reasons for them (brain fog, irritability, anger, etc) this presentation offers real-world tips on how to reduce symptoms and improve a sense of well-being. This presentation can be oriented towards leadership and leader principals or teams, generally.

3. Job Stress Pillars: Burnout, Compassion Fatigue and Moral Injury Presentation (45-60 minutes or can be done in a series of one each).

This presentation walks participants through an understanding of the biggest contributors to their areas of stress in a specific workplace environment (response), and what can be done to effectively and reasonably reduce symptoms of each.

4. Group dynamics, De-escalation and effective communication strategies presentation (30-60 minutes).

This presentation shares information and strategies about understanding when effective communication can and should take place from a neurological standpoint, being aware of obstacles, and engaging effectively (and reducing risk) when supporting people in crisis or those who are angry. We will address the strategies, dynamics and tactics related to being part of a healthy team. Group dynamics are complicated- even more so these days with a highly polarized social and political world. How can team members work well together when it comes to effective communication, productivity, and effectiveness in the workplace, without doing 'more'? We will cover data on effective work groups, and how those characteristics can be replicated in many sectors, even under high-stress conditions.

5. Building a Personal Coping Plan (30 minutes).

This interactive workshop helps participants through the development of a personal coping plan that they can use at work and at home. Based on best-practices from clinical and motivational psychology research, the techniques provided in this workshop will increase the likelihood of using effective, active coping for most participants.

6. Building your Core Values Pyramid © (30 minutes).

This interactive workshop walks participants through the identification of their personal core values and the steps needed to increase their orientation around them in activities of daily life. With a focus on communication, reactions, and behaviors, participants identify opportunities for increasing their personal sense of well-being through living their values in day-to-day interactions at work and at home.

7. LEND A HAND training / workshop (90 minutes, including breakouts).

This interactive training is designed to provide behavioral health support skills that are relevant for anyone to use in support of friends, family members or co-workers. It teaches a basic assessment process for how to support someone who is in crisis, and provides actionable, simple and real-life strategies you can use to intervene and support behavioral health needs that may come up at home or at work.

8. COPE, CALM, CARE training / workshop (3 hours).

OPE, CALM, CARE: Thinking, Feeling and Being- breaking down practical strategies for healthy life and practice. COPE: ***"Thinking"*** Skills for the workplace is focused on cognitive, thinking strategies and skills for tackling tough situations. Borrowing from and then expanding on CBT techniques we can all use in the day-to-day, specific workplace-oriented strategies are shared for healthy coping. CALM: ***"Feeling"*** Skills for the workplace is focused on learning how to use emotion regulation, modulation, regulation and physiological control to approach and respond to challenging situations and crisis more effectively. Building off of the COPE skills, we add in emotional and physical bio-feedback skills. CARE- ***"Being"*** Skills for the workplace. This segment of the workshop builds off of COPE and CALM and is focused on connecting with things that are bigger than each of us individually- finding meaning and setting goals that are right for us, engaging with others in a substantial way, and practicing adaptive, healthy strategies in our interactions with others.

9. Leadership and Crisis Recovery:

90-minute workshop focused on simple and accessible best-practices for supervisors and managers on leading through crisis and developing healthy team / work group culture with a focus on behavioral health. We will cover communication tactics and strategies during times of adversity or high-intensity, crisis recovery, and de-escalation skills. A basic description of common crises (grief and loss, regional or local disasters) will be provided, along with explanations of typical reactions and behaviors as well as appropriate and helpful responses in a workplace setting. We will focus on actionable steps that those in leadership positions can take to improve the wellness and functionality of their teams from a behavioral health lens, and the specific strategies used by highly successful teams during and after recovery from adverse events.

10. Disaster Behavioral Health:

This webinar will explore the global experience of behavioral health priorities during large-scale disasters or critical incidents including impact / rescue, heroic, and surge/ acuity phases of recovery based on examples from response work all over the world and in the US. We will address considerations for personal and professional preparedness, and must-haves for effective and efficient recovery practices at home and at work, and how disaster behavioral health differs from traditional medical support. We will also address cultural commonalities as well as distinctions that make this area of work very relevant to all healthcare providers and first responders.

Dr Donnie, Work - Life Balance

Dr Donnie is an international first responder and firefighter speaker for self care and behavioral health. With many years of expertise, he specializes in bringing healthy practices and practical, step-by-step work-life balances to departments for both work and home lives.

Workshops
https://donniehutchinson.com/

Proactive behavioral health
https://firstresponderbalance.org/

International Association of Fire Fighters

The International Association of Fire Fighters has several trainings available for fire fighters, paramedics and EMTs. These include Peer Support trainings, resiliency trainings, and recovery meeting resources.

Behavioral health trainings
https://www.iaff.org/behavioral-health/

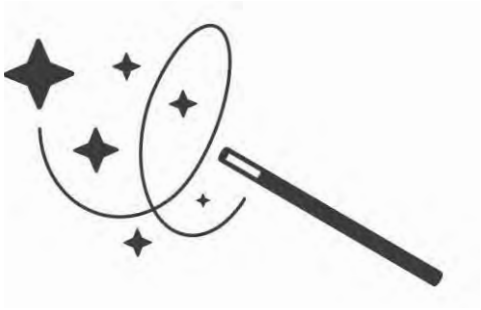
Firefighter Behavioral Health Alliance

The Firefighter Behavioral Health Alliance brings behavioral health workshops specifically for firefighters and EMS nationally and internationally, with an emphasis on behavioral health awareness, promotion of available resources, and suicide prevention.

Online workshops
https://www.ffbha.org/

APPENDIX C

IF YOU HAD A ***"MAGIC WAND"*** AND COULD GET WHATEVER YOU WANTED OR NEEDED FOR BEHAVIORAL HEALTH SUPPORT, WHAT WOULD THAT BE?



"Forward-looking proposals and a regional vision"

"A regional behavioral health unit with jobs solely to coordinate and assess mental health"

"A proposal for a wellness center with regional collaboration"

"A place for therapy, mental and physical, all kind of wellness things- in one place where everyone is trained to know how to help people in these roles"

"Learning how to talk to someone in crisis or how to handle it when it happens"

"More systemization, consistency, credibility, TRUST, and competency."

"Having dedicated staff solely focused on what they need".

"Knowing that I have resources outside of myself"

"More vacation days.. maybe more of a forced sabbatical"

"Better set of resources; immediate appointments; field specific; people will trust—is completely confidential and people KNOW that"

"A process that has been developed; someone overseeing the process; a place where you can grab someone and go talk to another department"

"A regional wellness center- somewhere everyone can go."

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King County Fire Chiefs Association

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