FIRST RESPONDERS SUICIDE PREVENTION TASK FORCE

FINAL REPORT AND RECOMMENDATIONS

101st General Assembly

December 30, 2020

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BILL CUNNINGHAM
STATE SENATOR
18TH DISTRICT

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STATE REPRESENTATIVE
35TH DISTRICT

December 22, 2020

The First Responders Suicide Prevention (FRSP) Task Force was created by Public Act 101-375. But it is important to note that the work of the task force was inspired by the family and friends of an Illinois firefighter, Lt. Ryan Elwood, who lost his life to suicide.

Lt. Elwood's death was a call to action for the people who loved him. They were determined to ensure that first responders who struggle with depression, post traumatic stress, and other pressures of the job did not suffer alone without access to much needed support systems. They formed an organization called RE;ACT, (Ryan Elwood; Awareness, Counseling and Training) which is designed to help break down the cultural stigma that often prevents first responders from seeking and receiving mental health services.

RE;ACT is one of many grass roots organizations and mental health advocacy groups in Illinois that are dedicated to better understanding and reversing the phenomenon of increased incidents of suicide among police officers, firefighters and paramedics. The FRSP Task Force is thankful to these organizations for the input and research they provided to our members. We are even more thankful for the important work they are doing on the frontlines of suicide prevention.

We salute all the members of the FRSP Task Force for the time and consideration they have dedicated to this important project. We are particularly grateful for the support of Illinois State Police Director Brendan Kelly, State Police Lieutenant John Thompson, and House Democratic staff member Victor Zepeda, all of whom were instrumental in organizing Task Force meetings and drafting the attached report.

Sincerely,

State Representative Fran Hurley
Co-Chair, FRSP Task Force

State Senator Bill Cunningham
Co-Chair, FRSP Task Force

Introduction

Public Act 101-375 created the First Responders Suicide Prevention Task Force (FRSPTF). Pursuant to 5 ILCS 840/30, the Task Force was created to "pursue recommendations to help reduce the risk and rates of suicide among first responders, along with developing a mechanism to help reduce the risk and rates of suicide among first responders." "The Task Force shall issue a final report to the General Assembly on or December 31, 2020, and, one year after the filing of its report, is dissolved."

This Final Report is a yearlong culmination of meetings, hearings, and ongoing discussions regarding the topic of suicide and the affliction it holds over our brave men and women serving on the front lines–Police, Fire, public and private EMS. The Task Force met on February 27, April 30, June 25, July 23, September 3, October 1, October 8, October 15, December 3, December 17, and December 30. This Final Report was approved unanimously at the December 30, 2020, video conference meeting.

Task Force Membership

State Senator William Cunningham (Co-Chair)

State Representative Frances Hurley (Co-Chair)

State Senator Neil Anderson

State Senator Brian Stewart

State Representative John Cabello

State Representative Terra Costa Howard

State Representative Brad Stephens

Jeffery Ivan Bennett, MD, Department of Psychiatry, Southern Illinois University Neuroscience Institute

Brendan F. Kelly, Director, Illinois State Police

Tom Howard, Executive Director, Illinois Firefighter Peer Support (ILFFPS, ILOEPS)

Geri Kerger, Executive Director, National Alliance on Mental Illness (NAMI), DuPage County

Jon Sandage, Sheriff, McLean County

Amaal V.E. Tokars, EdD, Assistant Director, Illinois Department of Public Health (IDPH)

Patrick McGrath, Detective, Chicago Police Department

Joe Panico, Senior Associate with Crisis Associates, LLC

Jonathan A. Zaentz, District Chief, Chicago Fire Department

Annette Zapp, CSCS, TSAC-F, Firefighter Advocate

First Responder Suicide

Whether EMS, Police or Fire, being a first responder is a stressful job. On a regular basis, our first line of defense personnel are exposed to difficult situations, traumatic events, and strenuous physical and mental duress. It is these reoccurring exposures, in addition to routine stressors in both personal and professional lives, which can negatively impact an individual's mental health and wellness, leading to an inevitable increase of risk adverse or depressive disorders, such as post-traumatic stress disorder (PTSD), substance abuse, addiction struggles, and suicide.

According to the Centers for Disease Control and Prevention (CDC), "Suicide is the tenth leading cause of death in the United States. It was responsible for more than 48,000 deaths in 2018, resulting in about one death every 11 minutes. Every year, many more people think about or attempt suicide than die by suicide. In 2018, 10.7 million American adults seriously thought about suicide, 3.3 million made a plan, and 1.4 million attempted suicide."

According to the CDC, "Responding to disasters is both rewarding and challenging work. Sources of stress for emergency responders may include witnessing human suffering, risk of personal harm, intense workloads, life-and-death decisions, and separation from family. Stress prevention and management is critical for responders to stay well and to continue to help in the situation. There are important steps responders should take before, during, and after an event. To take care of others, responders must be feeling well and thinking clearly."

The Runderman Family Foundation commission issued a report saying, "First responders (policemen and firefighters) are more likely to die by suicide than in the line of duty. In 2017, there were at least 103 firefighter suicides and 140 police officer suicides. In contrast, 93 firefighters and 129 police officers died in the line of duty. Suicide is a result of mental illness, including depression and PTSD, which stems from constant exposure to death and destruction."

According to the Final Report of the President's Task Force on 21st Century Policing, "Dr. Laurence Miller observed in his testimony that supervisors would not allow an officer to go on patrol with a deficiently maintained vehicle, an un-serviced duty weapon, or a malfunctioning radio—but pay little attention to the maintenance of what is all officers' most valuable resource: their brains." "Officer suicide is also a problem: a national study using data from the National Occupational Mortality Surveillance found that police died from suicide 2.4 times as often as from homicides. And though depression resulting from traumatic experiences is often the cause, routine work, life stressors, working long shifts, lack of family or departmental support—are frequent motivators too." The report further noted, "Support for wellness and safety should permeate all practices and be expressed through changes in procedures, requirements, attitudes, and behaviors. An agency work environment in which officers do not feel they are respected,

supported, or treated fairly is one of the most common sources of stress. And research indicates that officers who feel respected by their supervisors are more likely to accept and voluntarily comply with departmental policies."

According to the Runderman Family Foundation, "On average, police officers witness 188 'critical incidents' during their careers. This exposure to trauma can lead to several forms of mental illness. For example, PTSD and depression rates among firefighters and police officers have been found to be as much as 5 times higher than the rates within the civilian population, which causes these first responders to commit suicide at a considerably higher rate (firefighters: 18/100,000; police officers: 17/100,000; general population 13/100,000). Even when suicide does not occur, untreated mental illness can lead to poor physical health and impaired decision-making." The members of the Task Force noted another result of untreated mental illness is absenteeism.

By identifying the components listed below—it is the FRSP Task Force's objective to recommend a series of training and continuing education modules, which could be used to train administrators and first responders on the importance of self-awareness, mental health and wellness, and early detection techniques. Analysis will begin by addressing the cultural stigma most first responders are all too familiar with and each module's source of origin:

I. Stigma of Organizational Culture;
II. Depressive Disorders;
III. Peer Support;
IV. Training and Continuing Education;
V. Reporting Mechanism.

These recommendations are to be used and seen as reference points by agencies and organizations to assist with improving access, quality, recognition and acceptance of mental health resources. In order to advance suicide prevention efforts and promote a culture of acceptance and resourcefulness among all first responders, including the individuals seeking care or treatment.

The ultimate limitation of this report lies with the inaccuracy and insufficiency of reporting and data tracking when referring to the stigma of suicide among first responders. Unlike with line-of-duty deaths, there is no official central repository for such information. The scarce data currently available is collected by small non-for-profit groups, obtained through open-source information and independent study.

This lack of accurate and comprehensive data hampers organizations nationwide in developing effective suicide prevention strategies or gauge whether current implementation efforts are producing positive effects.

Recommendations and Components

I. Stigma of Organizational Culture:

Although significant progress has been made by departments and organizations statewide, more needs to be done to address and normalize the stigma that comes from acknowledging the possibility of an existing problem and coming to terms with the realization that an individual may need outside help.

It is the duty and responsibility of administrators, leadership, and fellow responders to usher in an agency-wide culture change, committed to encouraging self-awareness and mental health wellness.

FRSP Task Force members recommend agencies and organizations guarantee access to mental health and wellness services; these include but are not limited to peer support programs and providing ongoing education related to the ever-evolving concept(s) of mental health wellness. These recommendations could be accomplished by;

a. **Revamping agencies and organizations employee assistance programs (EAPs),**
b. **Urging health care providers to replace outdated healthcare plans and include more progressive options catering to the needs and abnormal risks shouldered by our first responders,**
c. **Allocating funding for public service announcements (PSA) and messaging campaigns aimed at raising awareness of available assistance options, and**
d. **Encouraging agencies and organizations to attach lists of all available resources to training manuals and continuing education requirements.**

II. Depressive Disorders

The compounding dangers and constant life-threatening nature of the job expose first responders to a variety of depressive disorders that if left untreated, can lead to risk of post-traumatic stress disorder (PTSD), depression, anxiety, substance abuse, and suicide.

However, prior to awareness of problem and administration of treatment—detection is key. Unfortunately, first responders' sixth sense does not come equipped with an "out-of-the-box," self-diagnosing feature. This is further hindered by the suppressive, out-of-sight out-of-mind mentality many first responders are conditioned and even expected to heed.

In order to target this automatic self-suppression instinct, first responders must be better trained on how to detect and identify signs and symptoms of an emerging disorder. Unfortunately, and more often than not, by the time fellow responders begin to notice signs of troubled patterns in fellow brothers and sisters, it will be more difficult to find effective treatments.

FRSP Task Force members recommend agencies and organizations sponsor and/or facilitate first responders with specialized training in the areas of psychological fitness, depressive disorder(s), early detection, and mitigation best practices. Such trainings could be accomplished by;

- **a. Assigning, appointing, or designating one member of an agency or organization to attend specialized training(s) sponsored by an accredited agency, association, or organization recognized in their fields of study.**
- **b. Seeking sponsorships and/or conducting fund-raisers, to host annual or semiannual on-site visits from qualified clinicians or physicians to provide early detection training techniques, or to provide regular access to mental health professionals,**
- c. **Requiring a minimum number of hours of disorder(s) and wellness training be incorporated into reoccurring, annual/biannual training standards, examinations, and curriculums—taking into close consideration respective agency or organization size, frequency and number of all current federal and state mandatory examinations and trainings expected respectively,**
- d. **Not underestimating the crucial importance of a balanced diet, sleep, meditation, and recreational hobbies, which have been scientifically proven to play a major role in the human psyche.**

III. Peer Support Programs

Considering the contemporary transition to community-based practices, enough progress has been made to where majority of Employee Assistance Programs (EAP) offer a variation of these programs; however, the stigma of admitting that help may be needed remains to persist. In order to circumvent this stigma and develop robust peer support programs, agencies and organizations must enlist the help and collaboration of qualified practitioners and responders' families. First responders often feel more comfortable approaching a peer rather than visiting with a third party, therefore implementation of this resource is imperative.

To ensure the most effectiveness of training(s) possible and to avoid any adverse effects of modules taught, it is imperative that administrators in charge of training do their due diligence when soliciting professional mental health and wellness training. The market for these important services is flooded with superficial Band-Aids that could prove ineffective in reaching responders therefore being a misallocation of time, personnel and agency resources. While sponsoring an on-site or off-site personal trainer, chiropractor, or dietitian training module may seem like a good start, administrators must realize that the underlining issues being discussed here have a much deeper point of origin.

Today, contacting a qualified source of care is as easy as reaching for your smartphone. Technology has played an important role in mental health awareness, early detection, and suicide prevention overall. Voluntary and non-for-profit organizations such as the American Foundation for Suicide Prevention (AFSP), the Illinois Firefighter Peer Support, the WeNeverWalkAlone program for law enforcement, among many others, have created online systems that give first responders a confidential way to talk to someone outside of their agency and to test themselves for stress, depression, and other mental health conditions. Some of these applications go as far as providing users with an anonymous online connection with mental health clinicians in their area, instantly.

FRSPTF members recommend administrators and leadership personnel solicit training services from evidence-based, data driven organizations. Organization with personnel trained on the analytical review and interpretation of specific field(s) related to the nature of first responders' exploits—e.g., PTSD, substance abuse, chronic state of duress. Further recommending funding for expansion

and messaging campaigns of preliminary self-diagnosing technologies like the one described above. These objectives could be met by;

a. **Contacting an accredited agency, association, or organization recognized in the field(s) of specific study. Unbeknownst to the majority, many of the agencies and organizations listed above receive grants and allocations to assist communities with the very issues being discussed here,**
b. **Normalizing help-seeking behaviors for both first responders and their families through regular messaging and peer support outreach—beginning with academy curricula and continuing education throughout individuals' careers,**
c. **Funding and implementing PSA campaigns that provide clear and concise calls to action about mental health and wellness, resiliency, help-seeking, treatment and recovery,**
d. **Promoting and raising awareness of non-for-profit organizations currently available to assist individuals in search of care and treatment. Organizations have intuitive user-friendly sites, most of which have mobile applications, so first responders can access at a moment's notice. However, because of limited funds, these organizations have a challenging time of getting the word out there about their existence.**
e. **Expanding Family and Medical Leave Act (FMLA) protections for individuals voluntarily seeking preventative treatment,**
f. **Promoting and ensuring complete patient confidentiality protections.**

IV. Training and Continuing Education

To administrators' credit, many agencies and organizations have been proactively pioneering innovative ways to bolster current trainings and continuing education forums—despite the financial duress being felt by most. Throughout the state, agencies are beginning to implement periodic mental health check-ups, or check-ins, for administrators and first responders. The mission and goal of this approach is to further promote the normalization of preventative mental health and wellness assistance, thus reducing the stigma against seeking care and treatment, and to assist in detection efforts of potential issues early on.

Additional evidence-based training includes the deployment of Mobile Training Units (MTU's) to agencies and organizations nationwide. This has proven to be a cost-effective, time-saving, and effective way of reaching first responders virtually anywhere to administer personalized trainings specific to their organizational demands.

Therefore, and in the spirit of continuing this momentum, FRSP Task Force members recommend agencies and organizations incorporate the following training components into already existing modules and educational curriculums. Doing so could be done by;

a. **Bolstering academy and school curricula by requiring depressive disorder training catered to PTSD, substance abuse, and early detection techniques training—taking into close consideration respective agency or organization size, and the frequency and number of all current federal and state mandatory examinations and trainings expected respectively,**
b. **Continuing to allocate and/or match federal and state funds to maintain Mobil Training Units (MTUs),**
c. **Incorporating a state certificate for peer support training into already exiting state-wide curriculums and mandatory examinations—annual state fire marshal examinations and/or physical fitness examinations. Subject matter of the certificate should have an emphasis on mental health and wellness, as well as familiarization with topics ranging from clinical social work, clinical psychology, clinical behaviorist, and clinical psychiatry,**
d. **Incorporating and performing statewide "mental health check-ins" during same times as already mandated trainings. These checks are not to be compared or used as measure(s) of fitness for duty evaluations or structured psychological examinations,**
e. **Recommending sophisticated trainings on the importance of preventative measures on the topics of sleep, nutrition, mindfulness and movement.**
f. **Law enforcement agencies should provide training on the Firearm Owner's Identification (FOID) Card Act, including seeking relief from the Illinois State Police (430 ILCS 65/10) and a FOID being a continued condition of employment (50 ILCS 725/7.2).**

V. Reporting Mechanism

All training components listed within this report are increasingly being recognized as essential elements of all aspects of training amongst first responders—not only for promoting mental and physical health and wellness, but for the broader goal of helping first responders find fulfillment and purpose in their lives and careers—and in turn, leading to less suicide.

Although good work has been done here, this is merely scratching the surface. Priority one should be to establish a nationwide centralized mechanism to help log and track data, analytical research, and make findings uniformly accessible, so we may begin to take accurate stock of what is working and what is not.

Despite individual organizations' best efforts, the extent of the problem is underreported. Collecting and tracking first responder suicide data should not be dependent solely on the efforts of small, volunteer, non-for-profit groups. Federal and state governments should take a proactive role by establishing a comprehensive centralized mechanism where data collection can be logged and analyzed using a national and comprehensive effort.

A central repository of information would yield a wealth of data researchers, agencies, organizations, and even legislators could use in order to develop and implement effective policies and programs to prevent suicide among first responders.

Currently, no agency or organization of first responders is required to report information about suicides within the ranks.

As of this report, the U.S. Department of Justice, Bureau of Justice Assistance is working toward the creation of a national database in partnership with Blue H.E.L.P., the International Association of Chiefs of Police, the National Law Enforcement Officers Memorial Fund, and other policing organizations.

That effort needs the support of policymakers and law enforcement.