Clinician Training: Fire Service Cultural Competency Training Program

Kristen Wheldon Psy.D., Battalion Chief (Ret.) Robert Avsec, Burton A. Clark Ed.D., EFO, Zachary Isoma, Psy.D.

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Introduction

Firefighters are at higher risk for psychological difficulties due to chronic exposures to potentially traumatic events, organizational stressors, substance abuse, and sleep deprivation (Carey et al., 2011; Jones, Nagel, McSweeney, and Curan, 2018). However, these professionals are less likely than the general population to seek mental health services for many reasons including, but not limited to:

- A lack of culturally competent mental health clinicians (one of the top five reasons offered by firefighters when asked to identify their barriers to professional mental health services; Gulliver et al., 2019).
- Few available fire service-specific cultural competency training programs for mental health clinicians.
- Any available fire service cultural competency programs have no published data on effectiveness.

This white paper aims to provide information for both mental health practitioners and fire service leaders to best understand the scope and magnitude of firefighter mental health needs as well as barriers that may prevent many firefighters and fire officers from seeking professional mental health services. To address these needs, the Fire Service Psychology Association (FSPA) has created a Fire Service Cultural Competency Program to develop culturally competent mental health clinicians and demystify professional psychology for firefighters, fire officers, and their organizations to increase comfortability and support the likelihood individuals will seek professional mental health services when needed.

Behavioral Health in the Fire Service

Several studies indicate fire service personnel have higher rates of depression, anxiety, post-traumatic stress, substance abuse, and suicidality than the general population. Regarding suicidality, Stanley et al. (2015) surveyed 1027 firefighters and found forty-seven percent experienced suicidal ideation at some point during their career. In contrast, high estimates indicate approximately fifteen percent of the general population experiences suicidal ideation (Nock et al. 2008).

Despite higher rates of behavioral health difficulties, fire service personnel are less likely than the general population to seek behavioral health services. For example, Gulliver et al. (2019) surveyed firefighters about their access, attitudes, and preferences about behavioral health services utilizing an online survey to collect data from a sample group of 2,156 professional firefighters. Most respondents (eighty-one percent) reported having access to behavioral health services through their fire department.

In contrast, some respondents from smaller fire departments shared they were less likely to have similar access. Another interesting finding was that more survey respondents (sixty-seven percent) suggested they would seek non-professional help from their spouse or family, despite having available programs. Sixty percent shared that they would use private and professional clinical intervention services. Firefighters with fewer years in service reported they

were more likely to go to a spouse/family member, coworker, or officer for help. In comparison, those with more years would be more likely to seek private, professional services.

While common wisdom suggests firefighters don't seek professional mental health services because of a stigma associated with seeking behavioral health care, few firefighters in the study explicitly reported stigma would prevent them from utilizing such services. Contrarily, sixty-eight percent of firefighters in the study conducted by Gulliver S. B. et al. (2019) reported they would not recommend behavioral health services to colleagues and cited stigma-related barriers were still among the most significant reported.

These study participants reported one of the most essential components of a successful behavioral health program was "clinicians who understand firefighter work culture," and shared lack of such culturally competent clinicians rated as one of the top three reasons preventing them from seeking behavioral health services. Research conducted by Johnson et al. (2020) also revealed firefighters expecting adverse outcomes from treatment, stigma, and structural barriers inhibit them from seeking appropriate treatment. These engagement factors likely interact at various times and influence firefighter mental health outcomes.

Furthermore, available literature suggests wide diversity between different fire departments and personnel types, which could impact the availability of culturally competent behavioral health services. For example, Stanley et al. (2017) sought to describe differences in psychiatric symptoms and barriers to mental health care between U.S. firefighters in volunteer-staffed and career-staffed fire departments, determine if there were more significant self-reported structural barriers to mental health care (e.g., cost, availability of resources), as well as to explain the differences in psychiatric symptom levels. The findings of their study indicated volunteer firefighters experience significantly higher levels of depression, posttraumatic stress, and suicidal symptoms when compared to career firefighters. Career firefighters reported relatively elevated levels of problematic alcohol use.

Regarding structural barriers to mental health care (e.g., cost, availability of resources), volunteer firefighters appeared more impacted, and the researchers suspected these barriers accounted for the differences in mental health variables between the two groups. The researchers endorsed the need to develop intervention strategies specifically tailored to the different needs of volunteer and career firefighters while increasing accessibility to the volunteer firefighters who appear to have limited access.

In a 2022 study, Pennington et al. further investigated the differences in the availability of, and barriers to, behavioral health care for volunteer and career firefighters. The findings indicated volunteer firefighters were less likely to report the availability of substance abuse, couples, or family services but more likely to report the availability of a trained peer support system and follow-up care than career firefighters.

Compared to career firefighters, volunteers endorsed they were five times more likely to consider cost a barrier to accessing behavioral health services. Volunteer firefighters, however, were less likely to report a lack of support from leadership, fear of breach of confidentiality, or clinicians who are unaware of work culture as barriers to care.

Both groups expressed equal concern about stigma's role as a barrier to seeking professional mental health services. The study's findings highlighted the importance of identifying ways to strengthen departmental resources and designing targeted interventions to increase access to behavioral health services.

In 2020, Johnson et al. explored ways mental health treatment for various firefighter populations could be enhanced by understanding fire culture, treatment barriers, practice implications, and research directions. The study reflected concerns about mental health and barriers to treatment vary by firefighter subpopulation (e.g., volunteer, career, wildland, and aircraft crash fire rescue) and geographical factors (rural vs. urban). Each of these groups experiences a unique firefighter culture. Therefore, it's incumbent upon mental health practitioners to understand the complexity and nuances of the firefighter vocational experience to serve subpopulations effectively.

Overall, there is a dearth of research on adequate behavioral health resources within the fire service. However, the available literature indicates low treatment-seeking among fire service members despite the high prevalence of behavioral health difficulties. Practice implications highlight how barriers to help-seeking can be addressed via peer support, informal support, telehealth approaches (e.g., digital storytelling), work-recovery strategies, mindfulness, and critical incident stress management. Furthermore, researchers suggest firefighters benefit from mental health practitioners utilizing specific updated clinical practice guidelines for different firefighter subpopulations. Emerging research in this area can facilitate a more advanced understanding of firefighter mental health, highlight research gaps, and create proper training of culturally competent mental health providers that incorporate these diversity factors.

Fire Service Culture

The above literature review highlights the lack of culturally competent clinicians as a significant barrier to help-seeking behaviors among fire service personnel and the need for providing culturally competent services in the fire service. The American Psychological Association (APA) defines culture as "the distinctive customs, values, beliefs, knowledge, art, and language of a society or community. These values and concepts are passed on from generation to generation, and they are the basis for everyday behaviors and practices."

A second definition is "the characteristic attitudes and behaviors of a particular group within society, such as a profession, social class, or age group." APA recognizes the importance of considering cultural variables when working with diverse populations. For example, the APA lists cultural competence among their 16 core competencies for psychologists. Moreover, research indicates the importance of providing culturally-informed care and treatment (Smith, Rodriguez, Banal, 2010).

The fire service is considered to be a unique culture from the general population, in part because of traditions, "brother- and sisterhood," paramilitary organization, trauma bonding, and shared values of teamwork, self-sacrifice, fortitude, courage, as well as challenges related to social learning, cohesion, and other groups dynamics. Therefore, cultural competency is a key component in providing medical and mental health services to the fire service population.

Firefighters and officers need mental health practitioners who understand their unique cultural dynamics. Mental health clinicians need firefighters to become knowledgeable about applying their discipline to the fire service and EMS professions. Fire service leaders and mental health professionals have not adequately recognized, understood, or supported this critical and symbiotic relationship.

At FSPA, we recognize the importance of building solid interdisciplinary working relationships to positively impact the mental health resources offered to fire service populations. Firefighters need culturally competent clinicians who know what firefighters do, why they do it, where they do it, and under what conditions they do it.

It is equally important that firefighters and fire officers understand the diverse types of mental health practitioners by way of levels of degrees, licensure types, and specializations, as well as the specific services they provide, how they offer them, and the legal (e.g., laws, regulations) and ethical codes they must adhere to as they do so.

The fire service has a psychological blueprint reflected in its culture. Although many people may recognize mental and behavioral health as a current hot topic or trend, the need for fire service psychologists and other mental health clinicians isn't going anywhere. It isn't confined to conversations about suicide or post-traumatic stress. It transcends reactions to traumatic calls. To exist with intention, fire service leadership must invest in our understanding of fire service psychology as it applies to individual firefighters, group dynamics, organizations, and the entire fire service.

The effects of post-traumatic stress (PTS) and other occupational stressors (lack of psychologically safe work environments, organizational betrayals, promotional processes, etc.) are some of the biggest challenges facing the fire service. Many fire service leaders and departments are ill-equipped to handle these inherent needs independently. These difficulties can be overcome; however, it will require a significant paradigm shift. The fire service and professional psychologists must work together to resolve these issues.

Firefighters and EMS providers are, by nature, problem-solvers. For firefighters who have chosen the fire service as a career, that is what they are paid to do. Volunteer firefighters (who constitute the majority of firefighters in the U.S.), desire to have a positive impact in their communities. Whether career or volunteer, they put out fires, assess and treat the injured, mitigate hazardous spills, and much more. They tackle these tasks repeatedly over the longevity of their time in the service.

The outcomes are generally favorable when they follow their training, protocols, and standard operating guidelines (SOG). Thus, firefighters and officers tend to take the same approach with many of their internal problems. Too often, fire department leaders think they can resolve organizational challenges with more training and education about the problems without fullying investigating and identifying the root cause.

For example, the continued sexual harassment of women in the fire service is one glaring example of how **technical solutions** (applicable to problems that the knowledge of experts can solve) are inadequate for addressing problems that need an **adaptive solution** (for problems that

require people to learn new behaviors). If we are to start moving forward in helping firefighters and EMS personnel with occupational and behavioral health issues, we must recognize we are looking for adaptive solutions. For those purposes, we need to utilize subject-matter-experts in psychology.

Access to mental health services is essential for emergency responders who face high levels of occupational stress and trauma. However, many hesitate to seek help due to a cultural stigma attached to a fear of mental illness. Peers and superiors may view fire service members who seek professional mental health care as weak, unfit for duty, or a liability in a culture where the white male majority (U.S. Bureau of Labor Statistics) still adheres to a traditionally-masculine based culture that emphasizes mental and physical toughness.

It is imperative to have specialized and accessible mental health services that cater to the specific needs of firefighters and EMS personnel and provide a safe and confidential space for them to seek support and treatment. By prioritizing the mental health of our emergency personnel, we can help them better cope with the demands of their jobs and ultimately provide better care for our communities.

A top priority for a fire and EMS department looking to develop a mental health support system for its people, or improve an existing program, is actively recruiting psychologists and other mental health practitioners. Fire department leaders must learn who these mental health practitioners are in their area, meet with them, and ask them to join the team.

Fire and EMS department leaders and mental health professionals must understand that there is no “one size fits all” approach for diagnosing and treating firefighters and EMS personnel affected by PTS. While the military services and law enforcement have systems in place to provide mental health services to their members, the fire services do not. Those systems are not congruent with many elements of fire service culture.

Warfighters (now the term the U.S. Department of Defense uses to describe soldiers, sailors, and Marines) are trained from the inception of their training on how to carry out missions against hostile combatants. That training prepares them for hazardous missions with the potential they will not survive and emphasizes the need to quickly assess a situation correctly so the enemy fails.

Law enforcement officers are trained at the start of their training to act as a single-unit resource (reference the Texas Rangers motto, “One riot, one ranger.”) Police officers are trained to quickly solve problems, protect the public, and potentially use deadly force to neutralize a threat. The majority of calls for service, however, involve incidents that have already happened (e.g., homicides, motor vehicle crashes, robberies) and situations where the officer must deal with citizens who are “under the influence (e.g., drugs, alcohol, stress).

Firefighters and EMS personnel are trained at the start to solve problems. The public calls for emergency services when they have an issue, and these professionals respond to resolve their problem. This is the primary reason firefighters are highly revered.

Most of the time, after an incident response, there is a resolution. Sometimes. firefighters and EMS personnel are negatively impacted, and mental health issues can manifest. Some of the psychological dilemmas include underlying negative beliefs, which can include:

- Believing they didn't solve the problem;
- Believing they didn't have the training or equipment to solve the problem;
- Believing departmental policies or rules or SOGs "tie their hands" when it comes to solving problems
- "Compassion fatigue" from solving many of the same problems or repeatedly seeing the same unwanted outcomes. (For example, the ongoing opioid drug epidemic may require responders to revive the same overdose victims multiple times).

Mental Health Licenses and Scopes of Practice

Mental health clinicians are identified using different titles. These titles reflect different levels of education, experience, licensure, and scopes of practice. Consumers need to understand these titles and appreciate what types of services the provider can offer. Clients should also be aware that each state utilizes different governing bodies to regulate licenses and the delivery of mental health services and to protect consumers of these services. It is essential for firefighters and fire service agencies who utilize mental health professionals to be educated about these factors before deciding which clinicians to use personally and professionally. This white paper references the California Department Of Consumer Affairs Guide To Healthcare Providers as one state-specific example of the concept.

The scope of practice describes what mental health providers can do if they gain the proper competencies to fulfill those functions. Scope of competence limits a practice because although a provider may have the primary education for licensure, not all providers have the additional training, supervision, and experience to provide specialty care.

For example, psychologists are authorized to conduct pre-employment screenings (scope of practice), but not all psychologists have that competency (scope of competence.) Students can work under a mental health clinician's license with that professional's approval. However, licensed clinicians can only supervise students seeking licensure at a level commensurate with the license the supervisors hold or below that standard. For example, The Board of Behavioral Sciences and Board of Psychology outline specific guidelines for this practice. Psychiatrists and Psychologists can oversee Board of Behavioral Science students because those license types have a larger scope of practice.

Mental Health Clinician Designations

Psychiatrists are physicians who specialize in preventing, diagnosing, and treating mental disorders. They work in private practice, hospitals, clinics, and the common services based on their scope of practice include research, direct therapy services, and prescription privileges. To obtain a psychiatrist certification, an individual must earn a Doctorate Degree (M.D.), complete a required number of supervision hours, pass a National Examination, and pass a State Examination for the state they wish to practice in.

Psychologists work in hospitals, clinics, counseling centers, or private practice. They provide individual, family, or group psychotherapy and design and implement behavior modification programs. Standard services a psychologist may offer are based on their scope of practice. They may include research, psychological testing (e.g., fitness for duty and pre-employment), direct psychological services, as well as the creation, maintenance, and effectiveness testing of behavioral health programs. The domains in which they offer services include assessment, operational support, management consultation, and clinical intervention.

Psychologists must earn a doctorate degree (Ph.D. or Psy.D.) and complete the required supervision hours. They must also fulfill a research requirement (many programs require the completion of a dissertation or research in the field). They pass a national examination testing their understanding of the field's underlying principles and a state examination to ensure their understanding of the specific laws and regulations for the state in which they practice.

Marriage and Family Therapists (MFT) work in clinics, counseling centers, and private practice. They use counseling or psychotherapeutic techniques to assist individuals, couples, families, and groups with marriage, family, and relationship issues. Standard services based on an MFT's scope of practice include therapy services. An MFT must earn a master's degree, complete a required number of supervision hours, pass a national examination, and pass the state examination for the state they wish to practice in. In California, per the Business and Professional Code, they cannot hold themselves out as psychologists even if they have a doctoral degree in psychology. The license determines appropriate representation.

Licensed Clinical Social Workers (LCSW) work in health facilities, private practices, and child welfare agencies. They use counseling and psychotherapeutic techniques to assist individuals, couples, families, and groups. They often refer clients to specific resources to improve their quality of life. An LCSW's standard services based on the scope of practice include therapy services. An LCSW must earn a master's degree, complete a required number of supervision hours, pass a national examination, and pass a state examination for the state they wish to practice in.

Educational Psychologists (EP) work in schools or private practice and provide educational assessment and counseling relating to academic ability, behavior, and other matters based on their scope of practice. An EP must earn a master's degree, complete a required number of supervision hours, pass a national examination, and pass a State Examination for the state they wish to practice in.

Professional Clinical Counselors (PCC) use counseling interventions and psychotherapeutic techniques to treat cognitive, mental, and emotional issues, including personal growth, adjustment to disability, crisis intervention, and psychosocial and environmental problems based on their scope of practice. To become a PCC, an individual must earn a Master's Degree, complete a required number of supervision hours, pass a National Examination, and pass a State Examination for the state they wish to practice in.

Stages of Clinical Training

The Fire Service Cultural Competency Program was developed as a professional vehicle for mental health professionals trained at the doctoral or masters level to gain the cultural competency to effectively work with firefighter populations as individuals, couples, families, and within organizations.

1. Classroom Training: The Understanding Fire Service Culture course provides a broad overview of the fire service and its psychological components. After successful completion, the participant can earn one hour of continuing education per hour of training The Fire Service Psychology Association's courses are sponsored by the American Psychological Association, which is the gold standard for continuing education in psychology. This determines the program's academic quality and ensures clinicians can earn continuing education hours toward licensure for attending the program.

   After completion of the classroom portion of the certification program, participants will be able to identify the cultural components of the fire service, including performance standards, jargon, shift work, and barriers to treatment. They can describe the complexities of firefighting and emergency service, including trauma exposures. They should be able to identify unique challenges to interpersonal relationships. They can explain organizational demands inherent in the firefighting profession based on the paramilitary organization. Lastly, participants will be able to explain current trends in peer support, psychological services offered to fire departments, and barriers to treatment.

2. Practical Fire Operations 101: This one-day class uses an immersive scenario-based format designed to give the mental health clinician an overview of some emergency operations–and real-life dangers–that firefighters and EMS personnel face daily.

   Before engaging in the scenarios, participating clinicians will be fitted with the structural firefighting protective ensemble (i.e., turnout gear) and learn how to don/doff a self-contained breathing apparatus (SCBA) unit. The clinician will learn how to use a halligan tool and ax to force entry through a door, practice chest compressions on a CPR training manikin, and how to deliver high-flow oxygen effectively to a patient with difficulty breathing. The morning learning and practice sessions will prepare participants for the immersive afternoon scenarios.

   Under an instructor's direction, participants enter a live fire burn building to experience the heat, smoke, zero visibility, and disorientation that firefighters face. Very few civilians ever have this first experience or glimpse into the cognitive, effective, and psychomotor domains firefighters work in. This experience is critical to understanding the fire service culture. This knowledge is so valuable, every year, the Congregational Fire Service Institute, in cooperation with the Maryland Fire Rescue Institute, sponsors this type of program for the U.S. Congressional staff.

3. Ride-A-Long and Task Book (40-Hour Experience):

The clinician and host Fire Department will jointly schedule dates and times for visits and ride-along. This experience will help clinicians put their previous learning into a real-world fire service culture. The clinician will better understand the fire service culture by spending 40 hours in a fire station learning equipment, apparatus, organizational structure, teamwork, training, and responding to emergencies.

This experience gives psychologists and other mental health practitioners the knowledge and understanding of the fire service culture so that they understand the jobs that firefighters do, the conditions under which they work and live, and the mental health exposures they face during work.

It also gives firefighters and fire officers the knowledge and understanding of how the discipline of professional psychology can provide them, both proactively and reactively, with the knowledge, skills, and abilities to enhance their job performance, more effectively process mental health exposures, and develop resilience for the mental health risks associated with their job.

The FSPA believes these can best be accomplished with meaningful and focused interactions between psychologists, other mental health practitioners, firefighters, and fire officers in the fire station environment. Such personal interactions can allow both parties to learn about each other and begin developing meaningful working relationships proactively.

Given the opportunity to work with a fire department, the mental health clinician will become informed and educated about the fire department at the fire station level, the environment firefighters live and work in, and the exposures to their mental health arising from their emergency responses and non-emergency work.

Task Book Objectives

- The clinician can describe the different roles and primary responsibilities for each position within the fire company.
- The clinician can describe the physical and emotional stress of working in the structural firefighting protective ensemble.
- The clinician can describe the physical and emotional stress of working in a low-visibility and high-stress environment.
- Given an emergency scenario, the clinician will describe how a fire company performs its duties.
- The clinician can describe the firefighter's “mayday” process.
- The clinician can explain how NIOSH Firefighter Line-of-Duty Death (LODD) Reports are used by fire officers in training their personnel.
- The clinician can describe the physical and emotional stress associated with working in a low visibility, smokey, and warm environment (This is optional, depending on the availability of an appropriate live burn facility and the clinician’s willingness to engage in such activity).

4. Consultations with Experienced Fire Service Psychologists: Mental health professionals are taught the importance of self-care at the start of their careers. Given the nature of the fire service and the occupational risk exposures inherent to the work, it is essential for clinicians working in this area to manage the risk for vicarious trauma, secondary trauma, compassion fatigue, and burnout.

   According to D. M. Corey et al. (2011), "…it's especially vital for specialists engaged in work that exposes them, personally or vicariously, to a high incidence of trauma. Known as 'practice in extremis,' these specialties require a high level of competence, but they also involve a heightened potential for erosion of competence through the same kinds of emotional and psychological mechanisms that affect public safety personnel (e.g., post-traumatic reactions, vicarious traumatization, compassion fatigue, burnout, empathy failure)." Consultation can serve as a vehicle for clinicians to reflect on their professional experience going through the training program and assist them in meeting their training objectives.

5. Evaluation: The clinician will evaluate two firefighter cases and successfully identify the cultural variables inherent to the cases. They will be expected to demonstrate cultural competency, and the FSPA committee will evaluate their responses to earn certification.

Conclusion

The review of the available literature, though limited at this time, clearly describes a conundrum regarding the mental health needs of firefighters. The fire service culture includes a stigma that inhibits a firefighter or officer from seeking professional assistance with a mental health issue because that knowledge by their peers or superior officers may cause them to be viewed as weak, not able to handle the job, and even inhibit their professional development and opportunities for promotion. Research also supports the notion that firefighters don't reach out for psychological services because they do not believe mental health clinicians are culturally competent to fulfill their needs.

On the other hand, mental health practitioners who are not informed and educated about these barriers to firefighters seeking mental health services (i.e., culturally competency) are ill-prepared to provide the mental health services a firefighter may need and overcome barriers to care. The Fire Service Psychology Association's Fire Service Cultural Competency Program recognizes the symbiotic relationship between professional psychology and the fire service while providing both disciplines with the knowledge, skills, and abilities to support the development of their interdisciplinary working relationship.

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