III. Conclusion

OVC remains steadfast in its commitment to provide TTA resources that build the field's capacity and further supports Vision 21. We encourage USAOs to remain abreast of our TTA offerings by visiting OVC's Web page, www.ovc.gov, and OVC TTAC's Web page, www.ovcttac.gov. OVC has also gone social, so please follow us on our Facebook page, on Twitter, and subscribe to our YouTube channel. ❖

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Mental Health and First Responders—Getting Smarter on Wellness

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I. Introduction

Getting smart on crime requires that we also get smarter about meeting the wellness needs of our first responders. Raising the performance stakes through our Smart on Crime Initiative also means increasing the mental health and wellness risks of all our first responders and support staff at the federal, state, and local levels. This article seeks to reinforce one of the key Smart on Crime principles—our need to leverage and share scarce wellness resources so that we are smarter and more efficient in caring for our brothers and sisters on the front lines.

Those of us within the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) who are supporting the wellness needs of our employees want to work more closely with our Department of Justice (DOJ) wellness counterparts (as well as with our state and local allies) to reduce stress impact and increase protective factors by leveraging our best wellness practices, resources, and tools. Although ATF's innovative, emotional first aid programs have kept pace with latest law enforcement stress management best practices and trauma research findings, we know that effective collaboration will ensure that our collective workforce has an adequate, effective, and extensive wellness arsenal with which to combat stress and trauma.

ATF's wellness program evolution also reveals that it takes supportive, hands-on executive leadership guiding the way in promoting preventive wellness strategies to de-stigmatize access to, and use of, effective mental health wellness resources and tools, which ultimately save lives. However, by working together, we can make opportunities to share resources, make transparent the best wellness practices, try new things, and innovate in ways we never thought possible.

II. First responder occupational risks: stress, trauma, and suicide

Not unlike soldiers returning from the battlefields, first responders, public safety officers, federal agents, police officers, prosecutors, support staffs, and even their family members, feel the impact of the 21st century battlefield, which is unlike any other because it also includes the cyber world, which has no borders. Addressing violent crime has the same devastating effects on the emotional health and mental well-being of our first responders, whether they work in the back alleys of our cities or via the Internet from the interior creature comforts of their home offices or workplaces. Over time, the cumulative effects can be devastating.

Although most of our first responders will never suffer the effects of traumatic brain injury from exploding improvised explosive devices, they may suffer from the continuous onslaught of horrific crime scenes and graphic images seen online. Those images often are lodged indefinitely and deep within the emotional brain so that reminders of the original events can trigger the same strong emotional and physiological stress reactions as when those images were first witnessed. *See* BESSEL VAN DER KOLK, THE BODY KEEPS THE SCORE: BRAIN, MIND, AND BODY IN THE HEALING OF TRAUMA 171 (2014).

Today, the stakes for stemming violent crime in the wake of this endless, borderless battlefield have never been higher. Our first responders deserve the best that we have. We now know the accumulation of law enforcement-related stress, critical incident stress, as well as the trauma of facing daily, life-threatening situations, takes its eventual toll on first responders on many levels.

A. Stress: law enforcement stress versus critical incident stress versus cumulative stress

To fully appreciate the impact and risks of law enforcement (LE) work, it is important to understand the kinds of stress impact we are dealing with, the variations of it, who is vulnerable, and why this is important in caring for our first responders. Today we know so much more about this enigma, "stress." We know that it is bad for us, that it wreaks havoc on our mental and physical health, and that too much of it can overwhelm our coping and resilience. Dr. Hans Selye, a 20th century endocrinologist, was the first to study the long-term physiological effects of stress. He formulated the General Adaption Syndrome describing how, over time, stress can overwhelm and exhaust us. However, he is also credited with the concept of eustress—the *good* kind of stress—helping us to see that not all stress is bad.

First responders face an onslaught of stressors the ordinary public does not have to face and cope with. Daily, they arrest violent criminal offenders, investigate gruesome crime scenes, and suffer the potential violent loss of their own and their comrades' lives. They witness violence and cruel, indecent human acts committed against innocent, defenseless victims. In ATF, our special agents, National Response Team members, and support staff members, investigate particularly horrific arson and explosives scenes, often involving loss of life. The sights, sounds, and smells of these crime scenes are particularly vicious: they attack all of the senses, and they are hard to shake. We call this kind of stress LE-related, and it has a trickle-down effect within the workforce. Although support staff and family members may never see the crime scenes directly, they are affected indirectly because they may hear about them, see pictures of the scenes, or read reports about the incidents. They are considered "secondary" and "tertiary" victims.

As if that is not enough, first responders are also exposed to critical incident stress (CIS). CIS occurs when LE responders are exposed to LE-related critical incidents, such as mass school shootings, precarious undercover situations, and violent assaults on themselves and/or their partners, for example. These critical incidents have the potential to overwhelm physical and emotional coping mechanisms and can trigger a variety of intense physical, behavioral, emotional, and mental reactions, which we often call "normal reactions to abnormal situations."

Drs. George Everly, Jr. and Jeffrey Mitchell are the two most noted psychologists who, working together, formulated the body of knowledge known as "critical incident stress management" (CISM).

CISM prescribes and advocates methods, strategies, and tools for managing CIS impact—through early interventions including on-site/post-scene support, pre-incident stress and trauma awareness education, and clinical follow-up—to prevent the long-term, cumulative effects of CIS. Even with early interventions, continuous exposure can reduce the resilience of most people, no matter how resilient they are. And it does not end there. CIS is compounded by the kinds of stress we all face from living in a multi-dimensional, modern world where family, friends, health issues, hobbies, and personal interests and expectations compete and vie for our attention.

B. Trauma, post-traumatic stress disorder (PTSD), traumatic reactions, complex PTSD and PTSI

Because first responders are on the front lines fighting violent crime, bearing witness to, or being in, a critical incident can cause traumatic reactions as well. As with stress, we also need to understand what we mean when we talk about trauma, PTSD, traumatic reactions, and trauma impact of LE work. Today trauma can mean many things, and in the LE arena these terms cast a very wide net and often mean "all of the above." What's more, exposure to law enforcement stress over time can look like trauma. Therefore, it is also important to understand how the groundbreaking research of the 20th century—via starts and stops—has shaped better understanding, awareness, and hence treatments and resources, and why we need to pay heed.

Few know that it was Sigmund Freud—an Austrian neurologist credited with founding modern psychoanalysis—who was one of the first physicians to observe the long-term impact of "trauma." As he was shaping the practice of modern psychotherapy, he heard countless patient histories of child molestation and sexual abuse, which caused him to form his theory on "hysteria" (his term for traumatic reactions). In his 1896 paper titled The Aetiology of Hysteria, he observed and articulated numerous symptoms, which today we call PTSD, dissociation, and somatic reactions. However, Viennese society was not ready to accept this truth, and so Freud was ostracized and forced to repudiate this theory a short time later. For all the groundbreaking work he did, he is also credited with single-handedly setting back trauma research by almost half a century, until the returning World War II combat veterans prompted physicians and clinicians to pursue their understanding of the "battle fatigue" symptoms they were observing.

Not until the 1970s did trauma research begin to proliferate because of the collective manifestation of trauma symptoms among adult domestic violence and child abuse victims, war veterans, prisoners of war, emergency response workers, and first responders. This growth gave rise to the first "Post-Traumatic Stress Disorder" diagnosis in the Diagnostic Statistical Manual (DSM)-III (1980) and the subsequent, improved versions of it, including the DSM-IV (1994), DSM-IV-TR (2000), and the current DSM-5 (2013) versions. The DSM is a guide containing a standard classification of mental illnesses used by the United States' mental health community. Therefore, in the scheme of things, our current understanding of it is still relatively new.

The current PTSD definition, in the DSM-5, brings to bear the deepest, most current understanding of clinical trauma impact. Each revision, in fact, kept pace with current research and gave us a better understanding of the true depth and severity of trauma exposure. This version actually goes so far as to name vulnerable populations such as first responders, crime scene investigators, and those exposed to repeated child abuse. In addition, "trauma" now has a category all its own. In the previous editions, PTSD was classified under the anxiety disorders because of PTSD's unique "arousal" symptoms. Furthermore, many people do not realize (and this bears added emphasis) that PTSD is the only mental health diagnosis (in today's version and in previous versions) that begins with an *outside event*—not an internal state—that involves potential death or serious injury and has the potential to cause a variety of troublesome symptoms.

Using the DSM-5, a physician or clinical counselor makes the PTSD diagnosis if the client meets the criteria for each of the four symptom categories: (1) intrusion (nightmares and flashbacks), (2) avoidance, (3) hyper-arousal, and (4) mood/cognitions. However, from the perspective of our first responders, one need not have all the PTSD symptoms (in each of the four categories) to suffer trauma impact. For example, following critical incidents, first responders might suffer terribly from uncontrollable, spontaneous, intrusive images or flashbacks of their incidents—hallmark PTSD intrusive symptoms—without experiencing reactions in the other three criteria categories. In this instance, we would say that these first responders are suffering "traumatic reactions."

Sadly, putting any of these names to the symptoms, whether we use PTSD or traumatic reactions, stigmatizes the people and the condition, and gets in the way of people seeking and asking for help. The writers of the next iteration of the DSM may change the name to PTSI, for Post-Traumatic Stress *Injury*. Dr. Frank Ochberg, a practicing psychiatrist and lifelong, preeminent trauma researcher, is leading this cause because he and others, including military leaders, believe the word "disorder" implies a pre-existing weakness, rather than having been injured by outside influences.

Furthermore, the next iteration could include a new and separate trauma diagnosis that some are calling "Complex PTSD." Dr. Judith Herman, in her 1997 landmark book, Trauma and Recovery: The Aftermath of Violence—From Domestic Abuse to Political Terror, proposed "Complex PTSD" to describe the unique constellation of life restriction symptoms caused by prolonged trauma exposure and victimization involving captivity and entrapment. Although it has not yet been included in the DSM, there are professional clinicians who recognize and treat it as a separate, distinct trauma-related disorder. To complete the full scope of trauma impact in the DSM, the next iteration could include the diagnosis, "Developmental Trauma Disorder" (DTD), proposed by Dr. Bessel van der Kolk. In his book, The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma, he makes a profound case for DTD and better describes the reality of prolonged childhood trauma and neglect and how this new diagnosis would lead to improved prevention and treatment for abused children.

C. Suicide: the ultimate price

Sadly, suicide is the ultimate price for unmitigated, prolonged stress and trauma. According to the 2012 Badge of Life Police Suicide Study, twice as many police officers died by suicide than by felonious assault. *See* 2012 POLICE SUICIDES: THE NSOPS STUDY, *available at* http://www.policesuicidestudy.com/id16.html. This statistic is tragic news, especially in light of the fact that today we know that suicide is preventable. The onus is on us, therefore, to mitigate the risks and to put resources, tools, and solutions in place to help our first responders.

Although we might not be able to prevent every suicide, those of us who support first responders need to know that we are doing all we can to mitigate the risks, to challenge the stigma of seeking professional mental health counseling, and to bring suicide out from under the carpet to challenge the outworn myths that keep us in the dark. One of the biggest myths is that suicide is a reflection of personal weakness. To the contrary, desperate people in pain will turn to suicide as a misguided attempt to solve their problems. They are not weak, and they do not want to die. They do want, however, to end their constant pain and suffering, and they have run out of coping tools with which to endure their growing pain, misery, and suffering.

Unfortunately, and despite our best efforts, people will die by suicide. Because dying by one's own hand is so counter-intuitive to the survival instinct, it is hard to accept that people can reach such a desperate place. If we can begin to imagine the realities of human suffering, then we can see the reality of what unmitigated stress and trauma can do, and increase awareness in order for people to feel free to seek help and to help others.

D. Risk summary

So, what does all this mean for our first responders? It means that the responsibility is on us—the organizations supporting first responders, public safety officers, and their families—to mitigate these unique risks by providing our first responder workforce with resources, tools, and support services; to regularly promote these tools via all available communication methods; and to remove the negative stigma of accessing mental health services by having leadership advocate and reward their use. Although we may not be able to prevent every suicide, we want to know that we have done everything possible to promote a workforce that is safe from ridicule and negative stereotyping for having availed oneself of the very resources that will help keep one safe, especially from self-harm.

III. ATF's lessons learned and evolution of best practices

A. Peer Support Program implementation

ATF has a positive history of supporting its first responders with innovative, state-of-the-art, emotional first aid programs and services. It was one of the first federal agencies to form, in 1989, a Peer Support Program (PSP), and it was featured as a best practice in the National Institute of Justice. *See* PETER FINN & JULIE E. TOMZ, NAT'L INST. OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, U.S. DEP'T OF JUSTICE, DEVELOPING A LAW ENFORCEMENT STRESS PROGRAM FOR OFFICERS AND THEIR FAMILIES 42–44 (1996). The PSP came about when a group of concerned managers, in the late 1980s, noticed how prolonged trauma exposure was taking its toll on the workforce. With our increasing involvement in rising drug, gang, and firearms-related crime and violence, we experienced more critical incidents, and hence, more CIS employee impact. In 1989 these managers enlisted the help of Dr. Roger Solomon, a leading forensic psychologist, who specializes in treating post-critical incident trauma. Dr. Solomon introduced to ATF the PSP concept and, with his help, ATF's managers recruited, trained, and formed ATF's PSP team.

The first responder peer model originally evolved from the successful Veteran Administration's (VA) "rap groups." Following the Vietnam War, the VA learned that our combat veterans were more willing to talk to their peers—the ones who had "been there, done that" and had fought in the trenches. Dr. Solomon helped ATF adapt this concept to our workforce to make ATF's PSP a welcome, emotional first aid experience. Our managers assigned ownership of it to a program manager, who in turn recruited and trained empathetic, caring LE responders to listen and "bear witness" by working one-on-one with our first responders. Peer support care incorporates a number of important prescription ingredients, including early intervention and the "bearing witness" of traumatic experience—two things that today we know profoundly and positively help first responders recover and that have the potential to prevent PTSD.

B. Critical incident stress management

In 1997, when I assumed program manager responsibility for the PSP, Drs. Everly and Mitchell were developing, writing about, and recommending critical incident stress management (CISM) standards and protocols for all public safety departments, including law enforcement, fire, and rescue departments. During my tenure from 1997 to 2000, I followed and implemented some of their CISM best practices with hands-on support from them and from other PSP pioneers, including Peter Killeen (a professional counselor now working with me as an ATF Wellness Counselor) and William Hogewood (former Prince George's County PSP Manager). Together, over time, we implemented CISM's triad of care described in Everly and Mitchell's 1999 book, Critical Incident Stress Management (CISM): A New Era and Standard of Care in Crisis Intervention (which today is still an LE CISM best practice). The book recommends: (1) preventive education (education and training as trauma prevention), (2) on-scene support/post-scene debriefings, and (3) referral for follow-up clinical care, if needed. *See* GEORGE S. EVERLY, JR. & JEFFREY

T. MITCHELL, CRITICAL INCIDENT STRESS MANAGEMENT (CISM): A NEW ERA AND STANDARD OF CARE IN CRISIS INTERVENTION (2d ed. 1999).

Prior to my arrival, ATF had been providing this triad of care, but I formalized the role of the Employee Assistance Program (EAP)—an outsourced program that provides free, professional counseling services 24-hours every day and at no cost to AFT employees—and the role of the training office to ensure regular, consistent LE stress awareness training and to promote EAP self-service. Although ATF excelled in PSP implementation—even to the point where we were supporting our state and local responders who did not have similar programs—there were some trade-offs with CISM implementation. By the time my tenure ended in 2000, I found that we had gravitated away from some of the original, effective, individualized peer care. In our efforts to ensure we were setting up proper, well-timed, well-executed group debriefings, we may have ignored the need to ensure immediate, concurrent, one-on-one peer support, as well.

In hindsight, however, I believe our formation of the Chaplain Program in 1996 may have made up for some of that trade-off. One of our most passionate PSP program managers, Special Agent (SA) Peter Mastin (retired), concurrently led the PSP and formed our Chaplain Program. The program added an entirely new cadre of caring, experienced, lay professionals to our existing PSP and EAP programs. SA Mastin recruited approximately 50 well-trained police chaplains, from all religious denominations, with extensive LE experience. Because I inherited oversight of both programs, I was able to integrate the PSP and chaplain resources and offer more options for post-scene, critical incident support services.

C. Present day: making the wellness program the platform for engagement, performance, and overall well-being

Our Peer Support and Chaplain Programs are still thriving and providing first-rate care. Today SA Joshua Knapp, who is also the program manager of our Medic Program, leads these programs. SA Knapp was the first to make mandatory the peer meeting, which has greatly helped to "de-stigmatize" the peer intervention. He has also articulated clear, written, and standard protocols for deploying peer resources. We know that our employees greatly welcome the caring and empathetic support they receive following difficult critical incidents.

Prior to SA Knapp's oversight, however, various managers had moved the program about in an attempt to find the right home and to make the right placement of it. In doing so, we inadvertently dropped one of the key components within the CISM triad of care—the preventive, "pre-incident" education and awareness. Though we would not have predicted it, this oversight may have amplified our suicide risk. During the mid- to late 1990s, suicide dropped significantly. Within the last decade, however, we have experienced a rash of devastating suicides, for which we needed serious action. Thus, at the beginning of 2014, our Director, B. Todd Jones, and Deputy Director, Tom Brandon, made suicide prevention and wellness program implementation our highest priorities.

But it wasn't just the suicide tragedy that led Lisa Boykin, Chief of the Human Resources Operations Division; SA Theresa Stoop, former Assistant Director of Human Resources and Professional Development (HRPD); and SA David McCain, Deputy Assistant Director (now the Assistant Director of HRPD) to formulate and implement ATF's Wellness Program. Chief Boykin, with her extensive management and employee relations background, knew and felt all too well the negative impact of organizational stressors in the forms of conflict and conduct issues, substance abuse, and overall performance decline. She trusted and knew that there had to be a better way to *prevent* these problems through *proactive sharing of preventive wellness, tools, and resources*. Therefore, in 2013, she implemented ATF's Wellness Program. Unlike other work-life benefit programs, she wanted the Wellness Program to focus on prevention rather than intervention.

At the same time, Chief Boykin initiated an innovative reform—she established and implemented the Human Resources Information Center (HRIC)—to ensure centralized access to, effective coordination of, and complete transparency of HR services and programs. This reform also helped set the stage for implementing ATF's Wellness Program. Like the HRIC, she tasked the Wellness Program with centrally coordinating wellness-related services and programs (among ATF's many, diverse wellness providers) to promote and empower employees with wellness tools, services, and programs, and to foster wellness for greater job satisfaction and employee productivity.

Chief Boykin has a passion for wellness, and she has staffed the Wellness Program with two other people who share the same enthusiasm. She implemented contract support through Peter Killeen, a professional counselor who for many years helped ATF implement successfully its PSP and Chaplain Programs. In addition, she recruited me to be ATF's Wellness Coordinator to oversee, guide, and manage the entire Wellness Program. Chief Boykin challenged me to oversee our suicide prevention awareness program—beginning with the ideas that I presented in December 2013 to our executive leadership—while concurrently building the Wellness Program foundation with which to promote in ATF better employee engagement and performance.

D. Setting and implementing four key suicide/wellness priorities

In 2014 we set four key priorities and incorporated them into all of our Wellness Program and project plans. First, we made suicide prevention our number one program priority. We implemented an aggressive suicide prevention awareness campaign to mitigate suicide risk factors and to increase suicide protective factors, with the hope of halting suicide altogether. Our direction and support came directly from Director Jones and Deputy Director Brandon, who leveraged a number of their staff meetings to engage the entire senior leadership team, as well.

Using all possible communication avenues, we reached out to our workforce through a series of monthly public service announcements addressing suicide myths; through a series of four articles, which were prominently featured in our monthly newsletter, Inside ATF; through a suicide prevention video, Tomorrow Will Come, which honestly engaged employees and family members impacted by suicide; and through sharing the National Suicide Prevention Lifeline reproducible posters, buddy cards, refrigerator magnets, and educational materials, at our Annual Health and Wellness Fair and during our Diversity Day Celebration.

Second, and concurrently, we implemented our Wellness Program with the goal of increasing the protective factors for stress, trauma, and suicide mitigation. We believed, and still do, that if we have a population entirely reached by wellness programs, we will eventually have little or no need of suicide prevention. Early on, we did several key things to give the Wellness Program the foundation and credibility it needed to influence long-term changes. We wrote a wellness directive that gave the program staff the authority to coordinate ATF's strategic wellness policies and procedures. We also researched and promoted all the free, 24/7 crisis lifeline and program resources provided by our own EAP, as well as the National Suicide Prevention Lifeline, Safe Call Now, In Harm's Way, and Substance Abuse and Mental Health Services Administration. Working with our Office of Science and Technology, we created an Employee Wellness Web page making all these resources, as well as our crosscutting resources, available at one click of the mouse.

Third, we engaged all our wellness counterparts by forming the ATF Wellness Steering Board (WSB), comprised of all the diverse wellness providers who daily support ATF's employee wellness needs. Prior to kicking off the first WSB meeting in August 2014, I arranged one-on-one meetings with all of the members to solicit ideas and ensure inclusion of our Equal Employment Opportunity, Ombudsman, Chief Diversity Officer, EAP, Victim/Witness Coordinator, Safety and Occupational Health, Worker's Compensation, Personnel Security Branch, and Telework program offices. Each of these organizations plays a vital wellness role, supplying important programs and services that contribute

to individual and organizational wholeness. As it turned out, the WSB was a solution whose time had come and was embraced by all. The WSB meets monthly, and its primary purpose is to enable information sharing and performance improvement through collaboration.

Fourth, we are incorporating wellness training, which encompasses stress, trauma, suicide, and resilience topics, into all the major Academy (Special Agent/Industry Operations Investigators) and leadership training programs to ensure that our employees receive training throughout their careers. We are giving presentations at various all-hands meetings and will soon provide brown bag training for all employees. In the training, we are promoting stress, trauma, and suicide awareness, and we are focusing on resiliency and recovery by promoting the most current, innovative recovery and resilience best practices, such as mindfulness, meditation, yoga, and deep breathing techniques.

E. Summary of wellness lessons well-learned

As they say, hindsight has 20-20 vision, and that adage is certainly true for us. To summarize our wellness "lessons learned," our story tells us that leadership makes all the difference. Our programs are flourishing because they are embraced and supported by our top leaders. It takes courageous leadership to encourage people to seek help. However, as we make program changes, we will need to be especially vigilant when making what we think are "ideal" organizational placements—because we don't want to drop or cut off, by accident, the very things that our employees need the most. This point may be moot because now we have a wellness program that casts a much wider net and focuses on building in protective, *preventive* resources and providing *preventive* education that promotes tools and strategies for lifelong wellness and effective self-care.

We will continue collaborating across our agency to build strong networks and advocates for wellness, and we will continue making transparent all our resources and ensuring communication is a two-way street so that creative, innovative ideas are shared by the rank and file. Daily, we receive suggestions and ideas, which we incorporate into our programs and services. We will need to continue recruiting wellness leaders who are passionate about wellness and who, by example, show others what it means to be well and balanced. The people who implement wellness programs must also be especially compassionate and empathetic. Certainly, they can be among those who have risen from the ashes: Who better to advocate for positive wellness than an employee who has been negatively impacted by stress?

We believe so strongly in doing what we are doing and knowing we are helping people and saving lives. This is why it is such a privilege to implement ATF's Wellness Program. We will also need to take care of those who are leading and supporting wellness programs. Vicarious trauma and compassion fatigue are real, painful outcomes of giving compassionate care over time. It is thus important to keep in mind that we have to look out for our caregivers, too.

Last, we must also be exceptionally mindful that in caring for our workforce and caregivers, we work hard not to re-traumatize—through our processes and procedures—the very people who have been injured performing our mission. The Substance Abuse and Mental Health Services Administration recently published its report on addressing trauma. *See* Trauma and Justice Strategic Initiative, Substance Abuse and Mental Health Services Administration, SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach 2–3 (2014), *available at* http://issuu.com/nibbana/docs/concept-of-trauma-and-guidance-for-. This publication provides a helpful service-delivery framework to ensure we are really helping—and not harming or further aggravating through our business practices—the people who most need our support and care.

IV. Going forward: together getting smarter on wellness

A. A new era requires a new model

DOJ's Smart on Crime initiative brought forth a meaningful era of crime prevention and intervention strategies. It is now time we use similar approaches in supporting our first responders, ones that require enterprise collaboration. We can look to our information technology (IT) counterparts for guidance and inspiration. The Clinger-Cohen Act reformed the way Chief Information Officers plan and execute technology solutions by working to meet the collective needs of the enterprise, rather than the individual needs of subordinate organizations. This approach avoids deploying costly, duplicative, stovepipe solutions. Taking this concept a step further, we could learn a thing or two from innovative enterprise IT architects who "segment" their business processes, assign expert "owners" to standardize enterprise-wide business processes, and deploy enterprise technologies across the agency. Although the vision is a lofty one, the same concepts could be applied to supporting our first responders: leveraging enterprise best practices and resources to decrease costs, while increasing and improving services. As with any big undertaking, we need to begin with small steps.

B. Collective challenges: stigma, organizational culture, resources, and training

Whether first responders serve at the federal, state, or local levels, they face the same obstacles and challenges that prevent them from seeking the help they need and which are outlined in a recent International Association of Chiefs of Police (IACP) report. In July 2013, the IACP, in partnership with the Office of Community Oriented Policing Services of the DOJ, hosted "Breaking the Silence: A National Symposium on Law Enforcement Officer Suicide and Mental Health." Symposium participants developed a national strategic plan to openly address the reality of officer mental wellness and suicide. To view the report, visit http://www.theiacp.org/Portals/0/documents/pdfs/Suicide_Project/ Officer_Suicide_Report.pdf.

Overall, the report wants LE organizations to reduce mental health stigmas by bringing parity to physical fitness and mental health; to end the silence about mental illness, especially given the unique risks that law enforcement officers encounter; and to promote mental health wellness through preventive strategies. In his letter, included in the report, IACP President Craig Steckler states:

> In reality, officer mental health is an issue of officer safety, and we should treat it as such. From body armor and seatbelt use policies, to self-defense and verbal judo training, we can all list a variety of measures available to ensure our officers' physical safety. But what are we doing to actively protect and promote their mental and emotional health?

COMMUNITY ORIENTED POLICING SERVICES, U.S. DEP'T OF JUSTICE, BREAKING THE SILENCE ON LAW ENFORCEMENT SUICIDES iii (2014).

The stigma is perpetuated by an organizational culture that has yet to catch up with the realities of LE work and mental health impact. For example, federal employees report to us their frustrations with the e-QIP questionnaire, which asks federal employees to report mental health counseling (excluding certain conditions such as bereavement and sexual assault) sought within the past five years. Employees tell us they fear their security clearances will be withheld for reporting such counseling, which makes them afraid of seeking early the very help they need. If we are to influence positive change, we will need to engage Congress and the Office of Personnel Management to find a better way to balance national security and first responder wellness.

C. Next steps for DOJ enterprise collaboration

Addressing these challenges takes time, money, and people. Like most federal LE agencies, ATF's support budgets have not kept pace with operational budgets, which are mission-critical, too—another reason for us to think smarter. For these reasons, we are especially grateful for Denise Viera's leadership and courage in opening up this dialogue across the federal enterprise. We benefited greatly from the recent Webinar training, "Helping Heroes: Promoting Law Enforcement Wellness," which she organized and moderated. We were able to incorporate into our training some of the key training concepts we learned from this Webinar. The training was provided by experienced law enforcement professionals with In Harm's Way, a non-profit organization devoted to providing top-notch, wellness training resources and speakers at no charge to LE agencies.

Building on this spirit of enterprise collaboration, ATF is initiating and sponsoring a DOJ interagency wellness forum. It plans to host its first meeting in March 2015, with the objective of inviting and sharing best practices, tools, and resources. The group will be comprised of component representatives who oversee EAP and wellness programs. We hope it will be well attended and will start a long overdue dialogue about how we can do better, by sharing resources and innovating new wellness best practices. We are hopeful that, together, we will get smarter about first responder wellness, and our first responders will benefit from the collaboration. Serving our courageous heroes on the front lines will help make Smart on Crime a successful endeavor. ❖

ABOUT THE AUTHOR

❑ **Katrina Masterson** is currently ATF's Wellness Coordinator/Suicide Prevention Program Manager. She oversees, implements, and coordinates wellness programs and services that mitigate stress and trauma, occupational risks, and promote preventive wellness resources and tools. From 1997 to 2000, she led ATF's CISM and Chaplain Programs, while concurrently filling the Associate Ombudsman position and guiding informal alternate dispute resolution. As a lifelong, staunch advocate for trauma victims, especially those who suffer prolonged trauma such as child abuse victims, prisoners of war, and first responders, she has studied trauma impact and worked to raise trauma prevention awareness. ✠