



RESEARCH ARTICLE

Work-Related Trauma and Mental Health in First Responders: An Assessment of Service Utilization Barriers in Mahoning County, Ohio

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ABSTRACT

Introduction: First responders in Mahoning County, Ohio, face unique stressors and high exposure to trauma which significantly impact their mental health and increase risks for PTSD, depression, and anxiety, but many first responders do not utilize the current available mental health resources. Despite growing awareness of these issues, a knowledge gap regarding barriers (stigma, cultural expectations and toughness) and a lack of peer support remain that deter first responders from utilizing these mental health services. Addressing these barriers is critical to improving mental health service use among first responders and advancing public health goals.

Methods: This study used a mixed method design to assess mental health service utilization by analyzing both quantitative data (stigma, trauma, workplace culture, demographics) and qualitative data (attitudes, accessibility, department environments). A survey was sent to 250 individuals and analyzed using SPSS and Quirkos software to identify key barriers to accessing mental health services such as stigma, confidentiality concerns, and cultural norms. Guided by the US Surgeon General's Framework for Workplace Mental Health and Well-Being and Andersen Model of Health Service Utilization, the study aimed to inform targeted interventions that improve access, reduce stigma, and foster supportive workplace environments.

Results: Data collected from 113 first responders in Mahoning County, Ohio, revealed that while 81.4% were aware of available, mental health services, only 50.9% reported utilizing them. Gender and department differences influenced perceived barriers such as stigma and culture, though not all associations were statistically significant. Thematic coding showed trends of stigma throughout responses and also reported unhealthy coping mechanisms, different perspectives of life, mental health issues (PTSD, depression, and anxiety), and current coping mechanisms.

Conclusion: This study looks at targeted mental health interventions among first responders in Mahoning County, Ohio, particularly for firefighters who face higher risks and fewer training opportunities. These findings can guide local agencies in implementing evidence-based strategies to support the mental well-being of first responders.

Keywords: Mental health utilization; Stigma; Trauma; First responders

INTRODUCTION

Background

As of the most recent estimates, the population of the United States is approximately 341 million.¹ Of those 341 million, 4.6 million are employed as career and volunteer firefighters, police officers, emergency medical technicians (EMTs) and paramedics.² First responders risk their lives daily to protect others and keep communities safe, routinely making

personal sacrifices by placing themselves in harm's way in service to others. First responders are exposed to high-stress and traumatic situations regularly while on the job, which greatly impacts their mental health. This is due to the psychological pressure they face due to this exposure. Previous research has shown that the impact of the job and the increased risk that first responders face significantly affect their mental health; these responders might experience anxiety, depression, and





PTSD symptoms, which could negatively affect both job performance and personal life outside of the job.³ First responders witness deaths, car accidents, near-death situations, natural disasters, and potentially national disasters such as 9/11, school shootings, and more. Having repetitive exposure to these events partnered with a high stress environment and physically demanding job can lead to conditions and behaviors such as PTSD, anxiety, depression, and cases of burnout. Those responders who regularly experience these events are at a higher risk of developing a form of PTSD and depression.⁴ During the training process many responders push themselves to their limits to be successful within the program and to guarantee they are a valuable asset to a potential hiring department. Many programs/schools require extreme physical activity and countless exams that ensure readiness for high-stress situations. This type of training environment is imparting stress onto those who participate in many ways. Physical stress brought on by overexertion during training could lead to injury, fatigue, and potential long-term wear on the body, while the mental stress of constantly preparing for exams and evaluations could cause anxiety, burnout, and mental overload. Emotional stress they might face refers to performance pressure and fear of failure within a highly competitive environment. Finally, one of the most important stressors these responders face during training is time management; balancing training, academics, and personal life can lead to a lack in self-care and feelings of being overwhelmed. Once they finish this grueling training, they then belong to a department that deals with high-stress situations and traumas almost every single shift. These first responders then continue to put themselves into vulnerable situations that affect their mental, physical, and emotional health for their entire career, then they retire and are left with no resources that can aid them. Unstable behaviors might be identified as early as training and could continue into retirement.⁵ These behaviors consist of risk-taking and impulsiveness (substance abuse, engaging in dangerous activities, or reckless driving to cope with stress or regain a sense of control in their lifestyles), avoidance (responders isolate themselves from family or friends to avoid discussing traumatic experiences), paranoia (responders might become overly alert or anxious about potential threats even while in a safe environment), sleep disturbances, aggression, or suicidal ideation. Some retired responders have a hard time coping with what they have witnessed during their service, and this might be due to underlying mental health concerns that might have gone unaddressed during their time of active duty. This might compound symptoms of PTSD, depression, anxiety, etc after leaving the service if they do not have a daily structure or support system at home, which suggests a need for intervention prior to and during retirement.⁶

Knowledge Gap

Even though there is current research on first responders and the correlation of mental health issues occurring from the job, there is a significant knowledge gap regarding factors that may deter them from utilizing mental health services. Due to lack of research and sources within this topic, this indicates that many responders are not seeking mental health services due to stigma and cultural barriers.⁷ A major barrier is the expectation of mental toughness or a lack of peer support

groups.⁸ A study looked at first responders and measured stigma surrounding mental health treatment and found that responders do not feel as though they can show weakness or have any kind of fear because that would indicate they are not up for the job.⁸ There is a need to address and understand these barriers. To create interventions that effectively address the needs and concerns of first responders they must be able to create a culture of support and encourage mental health utilization within this specific demographic (first responders). Healthy People 2030 (MHMD-05 Increase the proportion of adults with depression who get treatment: Target 69.2%) is relevant to this assessment because efforts to improve first responder mental health service utilization can contribute directly to this objective target. This is because it increases awareness and acceptance of mental health treatment within the first responder community. It also tracks a proportion of first responders with depression that seek treatment with initiatives as a model for other high-risk populations to link treatment gaps. Addressing these barriers in first responders is a vital contribution to the broader public health goal of reducing untreated depression in the United States.

Current Mental Health Support

In 2022, the Mahoning County Health Department in conjunction with Trumbull County, Warren, and Youngstown city health department conducted a Community Health Improvement Plan that addressed the needs of the community. Based on results from their assessment, in Mahoning County and Trumbull County, mental health was 1 of the top 5 priorities selected by respondents who filled out the needs assessment survey.⁹ In Mahoning County there are 2 main mental health support groups that work with first responders. The CISM (Critical Incident Stress Management) of Mahoning Valley was developed to deal with traumatic events and help those who witnessed or were involved with the event share their experience, feel their emotions, and learn about symptoms of stress and how to handle it.¹⁰ The term CISM is defined as a comprehensive, integrative, multicomponent crisis intervention system.¹⁰ Because CISM is considered a multicomponent, the program is able to meet the requirements of a larger number of various critical incidents that are experienced within various populations.⁶ The idea is to continue to build community resilience and support. In Mahoning County, CISM is run through the Mahoning County Mental Health and Recovery Board, providing services to first responders after a crisis incident occurs during a call. Responders have the chance to participate voluntarily and be an active member of the Mahoning CISM team and participate in various team interventions (group and individual) to ensure the well-being of other first responders and attend training sessions to continue to grow and improve CISM skills. Within the Mahoning County, CISM is where police officers receive their treatment should they seek it out, and many officers can become certified in CISM training. There are peer support groups that are led by other first responders who partner with CISM that focus on debriefing, defusing, grief and loss, crisis management, adjustment support, and pre-crisis education.

Similar to this program, the International Association of Fire Fighters (IAFF) has a program that focuses on behavioral health and well-being



of first responders and provides peer support groups made up of mental health professionals and other first responders. According to a March 2025 personal communication from Tracey Wright, Master Peer Support Instructor at IAFF, the IAFF peer support “is like CISM but is less formal in a formal way,” meaning that IAFF might provide the opportunity for responders to share in a setting that is less rigid and less intimidating. The IAFF peer support program grew in popularity during post 9/11. This is because the IAFF recognized that there was a growing need for behavioral health support within the fire community. A study conducted by Stanley et al examined risk factors of PTSD and suicidal thoughts among first responders and examined how occupational roles, sociodemographic, and physical health contribute to PTSD symptoms.¹¹ The study found the high prevalence of PTSD across all first responder groups with firefighters reporting a high career prevalence of suicidal thoughts and behaviors.¹¹ In 2009, the IAFF launched a Behavioral Health Awareness Initiative program that raised mental health awareness and substance abuse issues arising among first responders (firefighter specific).⁹ In 2017, IAFF opened the Center of Excellence for Behavioral Health Treatment and Recovery in the state of Maryland, which is a facility for treatment of IAFF members struggling with PTSD and other behavioral concerns.¹²

The peer support training program has a unique approach to mental health because it trains responders to support their peers in a time of crisis. These leaders utilize crisis intervention, listening skills, and psychological aid while emphasizing confidentiality, building trust among peers, and cultural competency and also attending workshops to cover topics like stress management, suicide prevention, and referrals to professional services within the area they are serving.¹³ Beyond crisis management, the IAFF support group extends its services to address personal challenges unrelated to workplace trauma. A common misconception is that these support groups are only meant for traumatic crises, but many individuals seek assistance for personal struggles such as divorce, childhood traumas, and other life challenges.¹⁴ The IAFF is continuously trying to expand and collaborate with mental health providers and conduct research through institutions that aim to better support responders effectively and enhance the peer support groups’ effectiveness.¹³ Although these services are readily available and qualified to deal with these issues, not everyone uses them, and this can contribute to the stigma surrounding mental health. According to Wright (personal communication March 2025), paramedics and emergency medical services (EMS) personnel often lack access to designated support programs. While some utilize CISM, many private ambulance companies do not offer such services. Without recommendations for alternative support options or education on available resources in their area, many EMS professionals go unnoticed, leaving their mental health concerns unaddressed.

Purpose

The purpose of this assessment is to identify and analyze barriers that prevent first responders in Mahoning County, Ohio, from utilizing mental health services, particularly for treating PTSD and trauma. By

assessing accessibility issues, personal attitudes, stigma, and organizational culture, the study seeks to uncover factors within the work environment and community that contribute to the underutilization of mental health services. These findings will inform targeted interventions tailored to meet the mental health needs of first responders.

The primary research question examines the key barriers including accessibility issues, personal attitudes, stigma, and organizational culture that prevent first responders from seeking mental health support and explores strategies to address these challenges. The hypothesis is that first responders in Mahoning County, Ohio, face multiple barriers that contribute to the underutilization of mental health services, with concerns about stigma, confidentiality, and limited access to appropriate services expected to be primary restraints.

Project SMART (Specific, Measurable, Achievable, Relevant, Time Bound) objectives are as follows: (1) By April of 2025 we will achieve a response rate of 70% of first responders surveyed. (2) By April of 2025, 60% of respondents will have identified at least 3 barriers to accessing mental health services. (3) By May of 2025 we will present recommendations to at least 80% of first responder agencies in Mahoning County.

This approach focused on comprehensive and community-based assessment of mental health barriers that were specific to Mahoning County’s first responders. It incorporated local factors like organizational culture and community-specific stigmas. Both quantitative and qualitative data were analyzed for barriers within accessibility, attitudes, and department environments which can lead to more actionable interventions. With this demographic and aiming for high participation rates, the assessment provided insights to fill the knowledge gap and allowed for solutions to reflect the needs of these first responders in the community.

METHODS

This study utilized a mixed methods approach, analyzing both quantitative and qualitative data to assess mental health service utilization among first responders in Mahoning County, Ohio. Quantitative data consisted of stigma, trauma, culture, and perceived importance. It also analyzed age, gender, and department type. Qualitative data consisted of analyzing barriers within accessibility, attitudes, and department environments. The primary objective was to identify barriers and attitudes that prevent these individuals from seeking mental health support following traumatic work-related incidents.

Participants and Recruitment

The sample consisted of firefighters, police officers, and EMS/EMTs/paramedics, ensuring a diverse representation of first responder agencies and their unique workplace experiences. Each agency follows distinct procedures and perspectives, which may influence their responses to the survey. To be eligible, participants had to currently be employed or retired from a department within Mahoning County, over 18 years of age, and have at least 1 year of experience to



ensure sufficient exposure to job-related stressors. Participation was anonymous and voluntary with informed consent required.

Procedures

Survey data were collected over a 1-month period (March 2025) via Google Forms and distributed through QR codes at the monthly union meetings and in email invitations sent to department members. Once responses were recorded, data were transferred into Excel, SPSS, and Quirkos, with all files securely stored on a password protected laptop. The final sample size was 100 with 113 completing the survey. No incentives or compensation were provided for participation.

Data Analysis

The survey (see Appendix) took 20 minutes for participants to complete and examined key variables including mental health utilization, workplace culture, barriers to access, and attitudes toward mental health services. The quantitative section included 34 questions measuring interval, ordinal, and nominal data. Interval data provided demographic context (age, years of experience), nominal data captured service utilization (yes/no responses, eg, “have you ever utilized mental health services or support groups?”), and ordinal data assessed factors such as barriers to access, stigma, and workplace culture through Likert scale responses. The qualitative component consisted of open-ended questions where participants shared their perspectives on workplace stigma, cultural norms, and the effectiveness of available mental health resources. Responses were analyzed using Quirkos thematic coding to identify common themes and patterns. The analysis grouped together responses and compared them to key themes such as stigma, confidentiality, and job-related stress that were identified from a sample of the data.

To ensure validity and reliability, a scaling system was used for measuring responses. Univariate and bivariate tests were conducted to examine relationships between independent and dependent categorical variables. These tests provided insight into how different demographic factors and workplace experiences influenced mental health service utilization. By employing a mixed methods approach, this study provided a comprehensive analysis of barriers affecting mental health service use among first responders. Findings from this research can help inform policies and interventions aimed at improving access to mental health resources, reducing stigma, and fostering a more supportive workplace culture within the emergency response community.

Theoretical Framework

This study applies 2 key frameworks to examine mental health service utilization among first responders: the United States Surgeon General’s Framework for Workplace Mental Health and Well-Being (Figure 1) and the Anderson Model of Health Services Utilization. The US Surgeon General’s framework outlines 5 essential elements to support mental health in the workplace. Protection from harm ensures safe working conditions while prioritizing mental health.¹⁵ Connection and community fosters a sense of belonging and inclusion.¹⁵ Work-life harmony promotes balance between both professional and personal responsibilities.¹⁵ Mattering at work reinforces employees’ sense of value and purpose within their roles, and opportunity for growth

encourages skill development, career advancement, and financial stability.¹⁵ Each of these elements serve to create a supportive and psychologically healthy work environment, promoting policies that reduce stigma and enhance mental health awareness.

Figure 1. Surgeon General’s Framework for Workplace Mental Health and Well-Being¹⁵



The Andersen Model of Health Services Utilization is used to identify factors that influence mental health service use within 3 categories. Predisposing factors categorize individual characteristics that influence service use before a need arises (stigma, cultural norms, lack of awareness).¹⁶ Enabling factors categorize logistical aspects that facilitate or hinder access (time constraints, privacy concerns, availability of resources).¹⁶ Need factors categorize perception of mental health needs and severity, determining whether an individual seeks professional care. This model is relevant to the assessment because the survey questions can be categorized within these 3 domains, which allows for a structured analysis of the primary barriers to mental health service utilization.¹⁶ This framework takes a comprehensive approach at understanding the challenges that first responders face in seeking mental health support and identifies opportunities for targeted interventions to improve access and reduce stigma.

RESULTS

Data collection concluded after 4 weeks in spring of 2025. The results provide insight into mental health service and support group utilization among first responders and the perceived barriers for seeking services such as stigma, culture, trauma, and importance.

Demographics and Characteristics

The survey was distributed to 250 individuals, with a target response of 50% (125 participants). A total of 113 individuals completed the survey, resulting in a completion rate of 42.5% based on the initial distribution. Of the 113 survey respondents, 53 were firefighters, 33 were police officers, and 27 were EMTs or paramedics. A majority of the respondents (78.8%, n=89) identified as male, while 21.2% (n=24) identified as female. Regarding duty status, 73.5% (n=83) were currently active duty,



and 26.5% (n=30) were retired. Only 13 respondents reported having prior military experience.

Of the 113 total respondents, 110 answered the question regarding years of service. Among them, 37.3% (n=41) reported having 1-10 years of experience, 27.3% (n=30) reported 11-20 years, 23.6% (n=26) reported 21-30 years, 10.9% (n=12) reported 31-40 years, and 0.9% (n=1) reported over 40 years of experience (Figure 2).

In terms of department type, 82 respondents identified as career first responders, 24 as members of combined career/volunteer departments, and 7 as members of strictly volunteer departments. Employment status data showed 84.1% (n=95) of respondents were full-time first responders, while 13 were part-time, and 5 were volunteers receiving no stipend.

Mental Health Knowledge

Of all 113 participants, 92 (81.4%) reported that they were aware of the mental health services available to them as first responders with 21 (18.6%) reporting they were not aware. While 57 (50.9%) respondents reported they have utilized mental health services or support groups, 55 (49.1%) reported they have not utilized these resources.

Gender vs Stigma

Chi-square analysis indicated no relationship between gender and stigma (P value=0.58 with a confidence level of 95%).

Gender vs Culture

Chi-square analysis indicated no relationship between gender and culture (P value=0.14 with a confidence level of 95%).

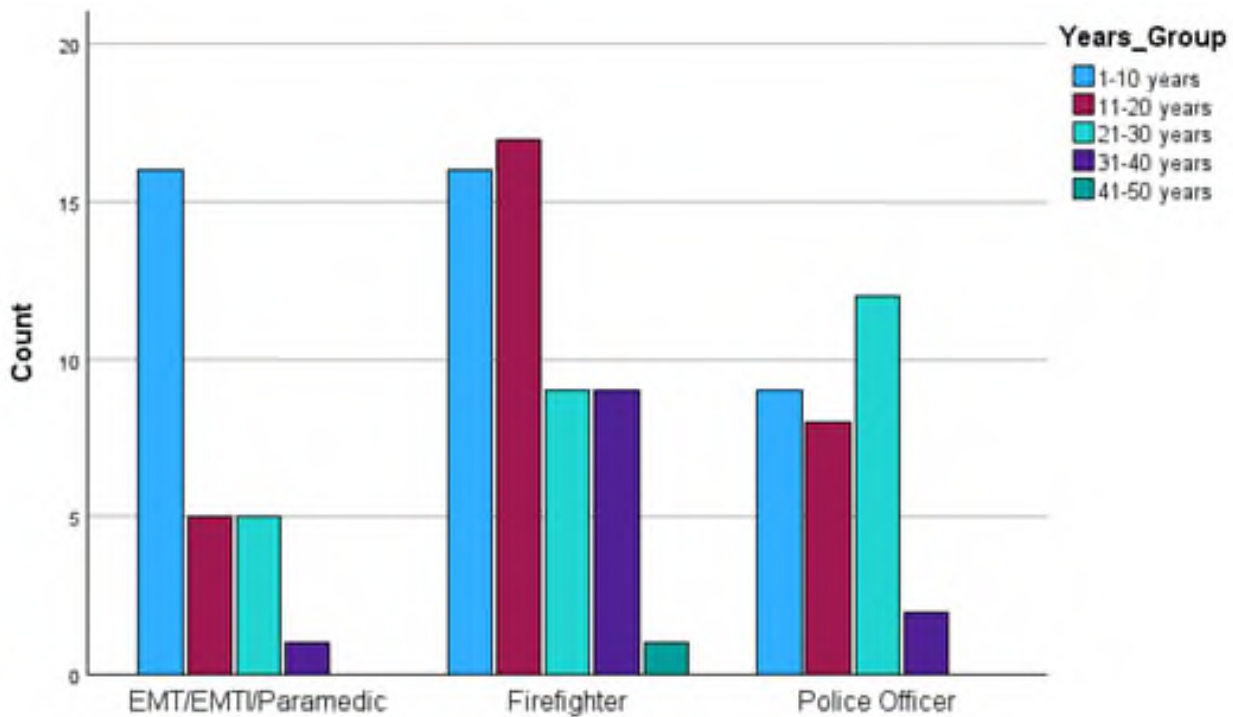
Department vs Importance

Chi-square was significant between department type and perceived importance with a P value of 0.01 and a confidence level of 95%. Specifically, a chi-square test was conducted to examine the relationship between department type and importance of mental health resilience training. Utilizing one of the survey questions, “Have you ever received any mental health training (eg, stress management, resilience building) as part of your job?” over half (of 113 responses) of first responders have received mental health training, but 45.1% of responders have not. Firefighters reported the highest rate of not receiving mental health training (31.9%), which suggests a potential gap in mental health preparedness within this group (Figure 3).

Department vs Trauma

Chi-square was significant between department type and trauma with a P value of 0.012 and a confidence level of 95%, which indicates a significant association. Specifically, a chi-square test was conducted to examine the relationship between department type and trauma that first responders experience and the negative coping mechanisms that follow. This test showed that firefighters have the highest percentage of respondents that developed unhealthy coping mechanism (22.1%) with only 3.5% of police officers and 12.4% of EMTs developing negative coping mechanisms. This shows that unhealthy coping mechanisms might be more prevalent in certain departments (Figure 4).

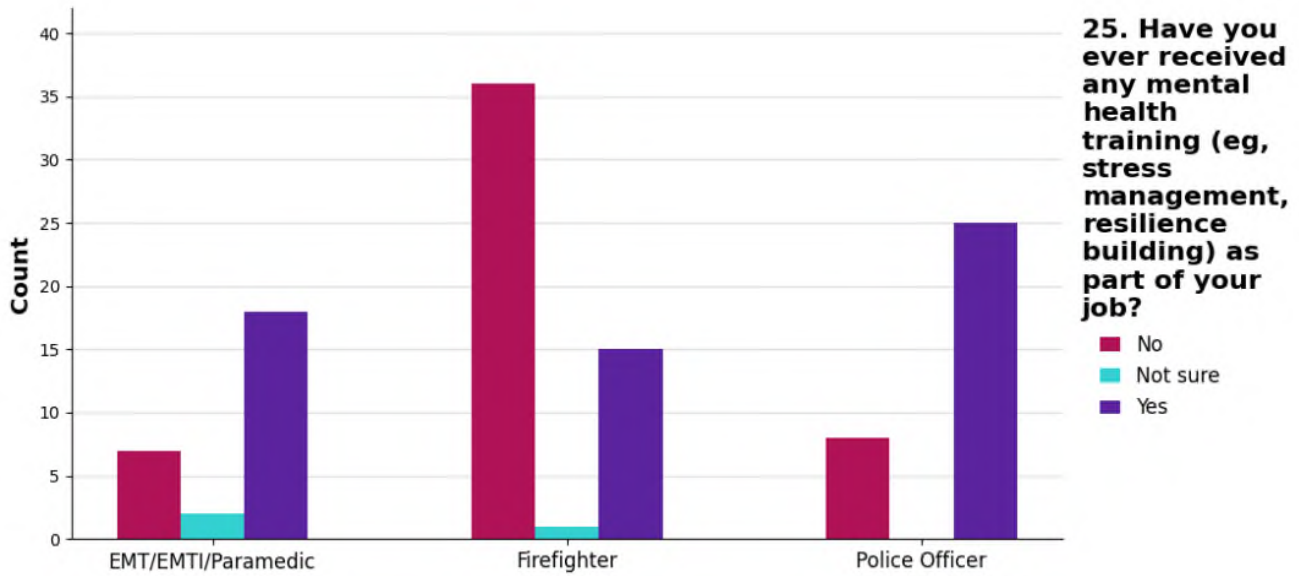
Figure 2. Bar Chart Years of Experience by Department Type



Abbreviations: EMT, emergency medical technician; EMTI, emergency medical technician intermediate.

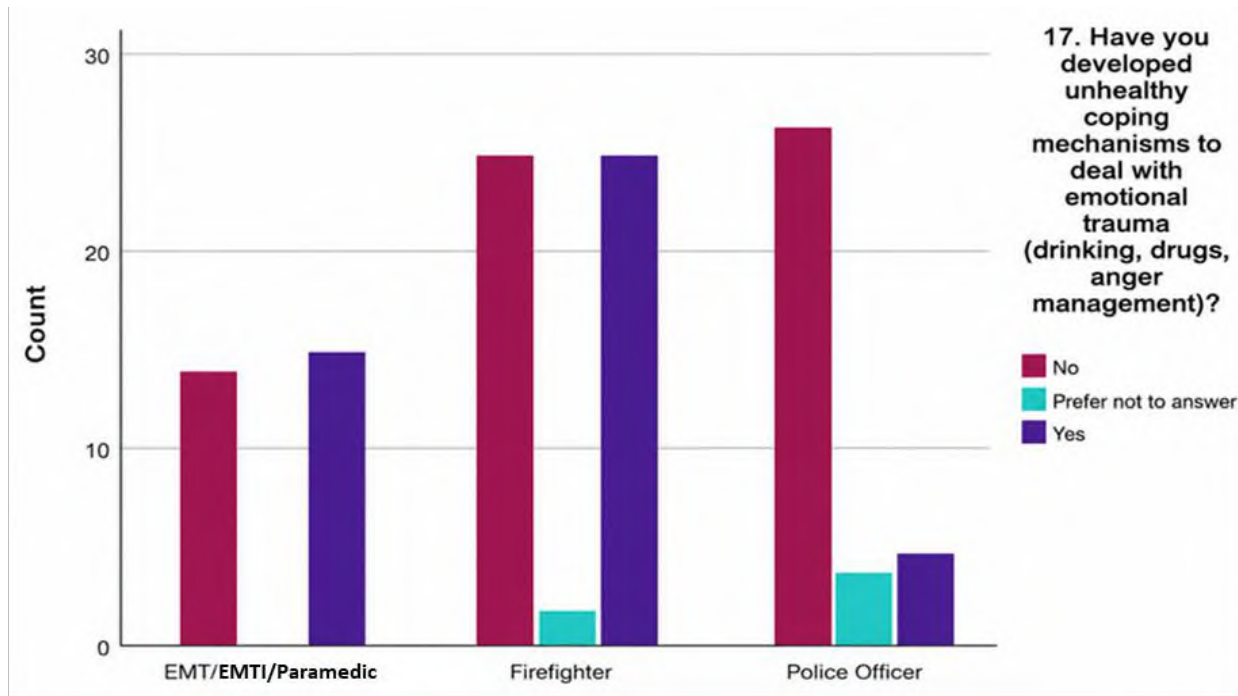


Figure 3. Bar Chart Importance of Mental Health Training by Department Type



Abbreviations: EMT, emergency medical technician; EMTI, emergency medical technician intermediate.

Figure 4. Bar Chart Trauma Exposure by Department Type



Abbreviations: EMT, emergency medical technician; EMTI, emergency medical technician intermediate.

Respondents were asked to address barriers that have prevented them from utilizing mental health services or support groups. Throughout this analysis, 9 main themes were identified from extended response answers:

stigma, none/NA, availability/accessibility, time, miscellaneous, lack of understanding, cost, tough it out mentality, and confidentiality. The top responses in each theme are shown in Table 1.



Table 1. Barriers Preventing Utilization of Mental Health Service/Support Groups—Themes and Responses

Theme and Top Responses Within Theme	
Stigma (18) ^a	<ol style="list-style-type: none"> Initially, I felt "weak" and was fearful of confronting thoughts, feelings, and emotions associated with the job Speaking with someone and being vulnerable about mental health concerns it is hard knowing that the issues will be from work, and there is a fear that supervisors and those within the department will find out about your stressors and mental issues. Groups are hard due to stigma and not getting the actual treatment that is beneficial. Just the general view of being weak or incapable of doing your job because of your mental health. When I first started in this profession it was somewhat frowned upon...
None/NA (18)	<ol style="list-style-type: none"> No barriers, I've never needed to use mental health services. None. If the need arises, I will seek help. I am aware of and comfortable with my cues and triggers so that I can focus on a healthy way of dealing with anxiety. None personally. Not needed. None at this time.
Availability/Accessibility (12)	<ol style="list-style-type: none"> The ability to quickly get a support team to the department after a major traumatic event. May take several days. Availability of first responder specific resources in our area. Blue star takes a long time to call back and was difficult to schedule with. There is more available now and I believe that I would have taken advantage of them had that opportunity existed. Availability, scheduling, or lack of trust from other people.
Time (9)	<ol style="list-style-type: none"> Number of hours spent on the job. Time management. Time management issues. Time. Time management.
Miscellaneous (7)	<ol style="list-style-type: none"> I don't feel like the group sessions are effective, no one really opens up and all you are doing is reliving the event. I'm not sure how to pick the right person for one-on-one counseling. The biggest barrier is the lack of mental health professionals that understand first responders. This lack of understanding makes it difficult to build rapport. For example, I was sent to counseling after a traumatic call where 2 teenagers died (murder/suicide pact). The counselor actually cried when I told her the story and was inconsolable. She couldn't process what we see as first responders. That was such a bad experience that it was almost a decade before I felt comfortable seeing anyone else. My impression of mental health resources was skewed because of that 1 bad experience. Thankfully my next counselor worked with veterans and other first responders, and she helped me immensely. Having counselors that are not informed about first responders can cause long-lasting harm for both the responders but can also harm any sort of trust in the mental health resources that are available. Reliving the tragedy. My department gave lip service to mental health but very little actual support. I found a competent therapist after my third try, but this was after a lengthy time (years) of shoving my thoughts and feelings down.
Lack of understanding (6)	<ol style="list-style-type: none"> Proper mental health services that focus and understand our jobs, not just general mental health. The provider doesn't understand first responders, can't tell them the issues, because they won't understand. The provider doesn't understand first responders. Having counselors that are not informed about first responders can cause long-lasting harm for the responder but can also harm any sort of trust in the mental health resources that are available. Can't tell them the issues, because they won't understand.
Cost (6)	<ol style="list-style-type: none"> Cost! It's always cost! Insurance and privacy. I think it depends on the cost of counselors and programs. Unfortunately, it is cost. Cost.
Tough it out mentality (5)	<ol style="list-style-type: none"> Early in career the "tough it out" mentality. Also, I don't like talking to people about my feelings. I've always been a "suck it up" kind of person. Also grew up in a household where mental health was viewed as make-believe. Barriers created by me. Thinking I don't need it. Always felt like I could get through it on my own.
Confidentiality (2)	<ol style="list-style-type: none"> Confidentiality is the main barrier. Confidentiality.

^a There were 83 total responses to the overall question. Numbers in parentheses represent number of responses matching each specific theme.

Respondents were asked how their mental health has been impacted by traumatic incidents that they have encountered during their roles as first responders. Throughout this analysis, 10 themes were identified: mental,

emotion, coping, change in life views, none/NA, unhealthy coping mechanisms, miscellaneous, seek therapy, lack of understanding, and keeping busy. The top responses in each theme are shown in Table 2.



Table 2. Mental Health Impacts—Themes and Responses

Theme and Top Responses Within Theme	
Mental (anxiety, trauma, PTSD, depression) (21) ^a	<ol style="list-style-type: none"> 1. Many years of post-traumatic stress and an eventual diagnosis with PTSD, as well as C-PTSD, had a personal and professional impact. Having worked in an environment with little to no support exacerbated feelings of an internal struggle. I experienced periods of depression, anxiety, and suicidal thoughts that led to poor coping skills and trying to find ways to “numb” such as exercise, overworking/overdoing, and binge alcohol use. 2. There are also other anxiety/trauma response like not feeling comfortable with anyone immediately behind me, having to always know the closest exit for any room I am in, getting nervous in large crowds, essentially anything where I don't have control of a situation. I have learned to live with many of these things mainly because the culture back then was to just suck it up and move on. 3. Not doing certain activities because of the reminder of something bad that has happened on a call. Not eating certain foods because the smell is a reminder of something. Simply just not caring about really anything because you've grown so numb to a lot of stuff. 4. Certain calls/faces/voices will never leave my head at one point or another. Not always there but definitely will always have a spot in my brain and memories. Brings up emotions every once and a while because of things I have seen. 5. Lack of sleep, anxiety, stress, anger, nightmares.
Emotion (17)	<ol style="list-style-type: none"> 1. Feelings of hopelessness and anger from seeing and dealing with constant negativity and trauma. Hopelessness comes from dealing with everyone's worst day and having to try and fix their problems. We often use our energy to help others with their problems and neglect to address the problems we are dealing with. You can sometimes find yourself in a dark hole of hopelessness when your internal struggles are left unchecked, leading to a feeling of anger and frustration. You can also feel hopeless when you've done all you can do and still have to see people struggle and suffer with their own problems that you are unable to solve. These feelings are sometimes brought home and cause tension between family members. When this occurs, you feel guilty for allowing it and sometimes lash out in anger as a defense mechanism. 2. More often than not there is no time to properly deal with or heal from a traumatic call, it's always "can you clear for another call". I have found myself getting angry throughout the day when I can't heal, or eventually several of the same traumatic calls pile up on my mind until it can't anymore, and I deal with it in ways that are healthy but somewhat excessive. 3. Self-isolation. Feelings of impending doom. Irritability. 4. Have become numb to traumatic events. Sometime lacking compassion. 5. My sympathy and patience for people is at an all-time low.
Coping (10)	<ol style="list-style-type: none"> 1. "Screws you up for a few days, then you file it away and move on. It's part of the job. Once you realize that you're going to see bad stuff, you get used to it. Being with your crew, those who experienced it with you". 2. Young people struggle when they first start seeing the traumatic stuff. Other older guys, talking, sharing similar experiences, and how to deal with them really help those struggling. I have personally talked to guys on the job about traumatic incidents and have helped them, telling them they did all they could do. And its “normal” in our line of work. Sad but true. 3. You learn very quickly to compartmentalize. Things that may seem very traumatic to civilians are never 'that bad' to you. Other life stress has a greater impact on your mind when you spend 5 days a week helping others with theirs. 4. I have seen the worst of the worst in my time as a city police officer. I leave it at the front door when I get home. It doesn't stay with me. 5. Typically, immediately following an incident is when we have first responders that are most reflective; never during.
Change in life views (9)	<ol style="list-style-type: none"> 1. Now that I am about 20 years into my career, I have noticed how many of my trauma responses are ingrained into my normal daily habits. For example, I had a call years ago where a 1-year-old was not strapped into a shopping cart and fell. The child had a skull fracture, major brain bleed, and almost died. Now that I am a parent, I experience an anxiety attack if my daughter is in a shopping cart and is not strapped in. It is to the point that everyone that goes grocery shopping with me knows to get a cart with a working seat belt. 2. Raising my children. They have not been allowed to do activities based on the stupidity and negligence of others. 3. It makes it feel like everything outside of work is not a big deal. 4. I'm the type of person to say it hasn't affected me at all. But I'm sure it has. I know over the last 6 years I've changed. It would take a professional to figure it out, I guess. But I guess my view on life and death has changed. Also, my sympathy and patience for people is at an all-time low. 5. I would like to say it has impacted me by being more cautious with people and relationships that I have with others due to an incident that took place. This particular incident, I responded to a call where a friend of mine was actively committing suicide. You become more guarded in relationships.
None/NA (8)	<ol style="list-style-type: none"> 1. Not at all. 2. None that I know of. 3. None at all. 4. None. 5. N/A.
Unhealthy coping mechanisms (7)	<ol style="list-style-type: none"> 1. Severe depression, alcoholism, drug addiction, relationship issues, and health issues. My career ended from an “in the line of duty” injury. Thank God I was able to battle and beat these issues. Had no help from the city or work comp. 2. It has not negatively affected relationships, but at times I put my family members and loved ones in place of victims I have encountered which causes periods of fear. 3. PTSD. Anxiety. Stress. Increase in alcohol use. 4. Reliving the event in my head once in a blue moon. 5. Loss of sleep, drinking, quick tempered.



Miscellaneous (7)	<p>1. Over the years, I have seen and experienced things from murders to serial assaults. Sometimes circumstances of a case or incident bring things from the past to the surface but knowing that those things are part of the job and you did what you had to do helps keep things in perspective.</p> <p>2. There are things in life that your average person will never have to see, and things that when you do you know will stick forever, if not just for a long time. Being an empathetic individual is incredibly taxing on a first responder when you have to assess the situation, handle the situation and then tackle everything else in between and thereafter all while maintaining some sort of decorum that will not tarnish the company or yourself.</p> <p>3. It has had a significant impact. I've worked in very busy urban environments. The volume and acuity of calls varies based on where you work, but for those of us that have worked in those busy environments and had repeated exposure, I think the stigma is there more to put it away and keep moving.</p> <p>4. Management insisting you go back in service immediately, push on fast turnaround time.</p> <p>5. I try not to let it affect me. But it may add to stress of everyday life. I am sure that being able to relax and get good REM sleep.</p>
Seek therapy (5)	<p>1. I see a counselor at least every 3-4 weeks now just to help with life stress and past trauma.</p> <p>2. Usually, the days after a high acuity incident will be hard until CISM or peer counselors come to talk.</p> <p>3. I have experienced this firsthand and took it upon myself to seek counseling to help me cope with and solve my own issues.</p> <p>4. Seeing death needs to be dealt with.</p> <p>5. I feel it is the best therapy you can do to help yourself. We talk about it and when we do that, we decompress and digest and accept what has happened. I had crew members usually.</p>
Lack of understanding (3)	<p>1. Outside of our job, mental health workers DO NOT understand. They don't. This is why I have low faith in outside services. Others have had success. We in the fire service, unfortunately, are different, we think, feel, and see things traumatically...different".</p> <p>2. I struggle with communication because I've always kept my feelings in because I always felt like I wasn't understood. People don't understand how tired you can be mentally and just wanting to zone out.</p> <p>3. I can't relate to people like I used to. I became a loner to an extent.</p>
Keeping busy (2)	<p>1. It has forced me to develop an ability to sequester my bad experiences and close myself off from them like putting them in a sealed room. Trust me, when I open the door to the room, I remember each experience in full detail and color, but so far I have been able to close the door and walk away mentally. I have developed other interests that replaced the fire service leg on my stool and added maybe more legs and stability. For how long I don't know. This is the cross we all bear when we do this job. Sometimes it becomes too much for some.</p> <p>2. I'm more isolated than I want to be. I have friends I can solidly rely on however I find I'm much less social and would rather stay busy doing other stuff.</p>

^a There were 89 total responses to the overall question. Numbers in parentheses represent number of responses matching each specific theme.

DISCUSSION

Significant Findings

This assessment aimed to examine and analyze barriers that are preventing first responders in Mahoning County, Ohio, from utilizing mental health services. By assessing accessibility issues, personal attitudes/traumas, stigma, and organizational culture, this study sought to discover factors within the work environment and community that contribute to the underutilization of mental health services. The hypothesis was that first responders in Mahoning County face barriers, which contributed to the underutilization of mental health services and, based on both quantitative and qualitative data, we were able to show that there were significant findings linking barriers analyzed (stigma, trauma, accessibility issues, personal attitudes, and organizational structure). By utilizing a framework from Kshtriya et al, this study looked at gender against stigma and culture and department type against importance and trauma.³ Univariate data looked at 3 independent and 4 dependent variables by utilizing bar charts to display data and show a clear understanding of distribution. Bivariate data looked at gender and perceived stigma towards mental health service utilization with chi-square test results determining that there was no statistical significance between gender and perceived sigma. Only 21.2% of the survey respondents were female, while 78.8% of participants were male which might have skewed the data. Based on this, although there is no

significant association, gender differences in perception do exist because females tended to perceive stigma more strongly based on survey answers. The next observation was gender and culture and if gender influences beliefs about a “tough it out” culture in a first responder setting. The data concluded that there was no statistical significance because the P value was 0.144, but females strongly recognize the presence of cultural expectations against seeking support. The third chi-square test explored department affiliation impacts on whether respondents received mental health training. There was statistical significance because the P value was less than 0.05 (0.01) and we concluded that firefighters are significantly less likely to receive mental health training. Police officers show the most consistent access to training across comparisons. The final test assessed differences across departments in the development of unhealthy coping strategies following trauma exposure. The P value was 0.012 which is less than 0.05 so the data concluded that there was statistical significance. Based on the findings, firefighters are significantly more likely than police officers to report unhealthy coping. Firefighters and EMS reported at similar rates, and police are the least affected group in this regard. Qualitative data found themes of stigma being perceived as a barrier among extended responses. Another notable theme was lack of accessibility and availability of counselors due to work hours or lack of resources being provided. Another common theme was the development of mental issues



such as PTSD, anxiety, and severe depression among first responders who responded to the survey.

Overall Patterns

Gender does not show significant associations with stigma or cultural expectations, but female respondents more frequently reported higher stigma and stronger cultural pressures. Department affiliation is significantly associated with both access to mental health training and development of negative coping behaviors. This data also showed that firefighters are consistently at higher risk for lacking training and reporting unhealthy coping strategies. Police are most likely to receive mental health training and least likely to develop negative coping behaviors, while EMS personnel fall in between firefighters and police across metrics.

Comparisons

A prior study⁴ focused on peer support programs and the role they play in reducing stigma and then improvement of access to mental health care among first responders. The results of this study provide evidence for implementing peer support systems within departments. The cross-sectional study predicted 3 major mental health outcomes (PTSD, anxiety, and depression).⁴ This indicates the importance of the high levels of social support in first responder environments.⁴ Key findings included increases in participants' self-efficacy and intention to engage in supportive peer conversations and higher baseline levels of trust in peers. Horan's study aligns with this study because although there was no statistical significance found between gender and perceived stigma; qualitative responses revealed that stigma was an overall recurring theme and supports the idea that stigma is a real barrier with Horan's model validating the themes from qualitative responses.⁴ Mental health issues and trauma were also recurring themes within the qualitative data which aligns with Horan's study.⁴ Another study³ examined how social support buffers negative effects of occupational stressors on mental health outcomes (PTSD, anxiety, depression) in first responders.³ This study found that increased perceived social support reduces the psychological burden of job stress. Greater occupational stress correlated with lower perceived social support which links to more severe mental health symptoms.³ There is a correlation with this study because it confirms that occupational trauma is leading to mental health symptoms. Although Kshtriya's study did not analyze the differences across department type this study further extended Kshtriya's because it showed how occupational stressors impact and vary by department type.

Strengths and Limitations

This assessment was able to address a critical issue and explored why first responders aren't utilizing mental health resources that are currently provided for them. There was a sample size of 113 and this assessment utilized chi-square tests, also looking at mean, standard deviation, and bar graphs to report data. These findings can help first responder departments address current barriers to using mental health services and

can inform efforts by other agencies such as health departments and emergency services to improve support systems. Some limitations of this assessment might have been the disproportion of male to female and of firefighters as opposed to the other 2 emergency groups. This study had only 24 females participate with 89 male respondents; 53 firefighters, 33 police officers, and 27 EMS personnel, which might have skewed data collection. In addition, some questions did not receive 100% participation which allowed for gaps in data collection. This might have weakened conclusions. Another limitation might have been questioning type; the number of levels of the Likert scale approach might have weakened analytical strength. Using only 2 or 3 levels, as opposed to 5, might have strengthened the statistical approach.

Recommendations

Targeted mental health training should be prioritized, particularly for firefighters who demonstrated the lowest training participation rates and a higher likelihood of engaging in negative coping behaviors according to survey findings. Departments are encouraged to develop comprehensive mental health policies that address the distinct needs and experiences of police, fire, and EMS personnel. Integrating a dedicated mental health counselor into each department, available to support responders following high-stress or trauma-related incidents, would complement existing peer support programs and offer an additional layer of care. It is essential that these counselors possess specialized knowledge and experience working with first responders to foster trust and create a more comfortable and effective clinical environment. Additionally, gender-sensitive stigma reduction initiatives and culturally competent mental health responses should be embedded into department practices, alongside the continued expansion of peer support systems. Finally, departments should implement ongoing evaluation processes to monitor effectiveness of mental health interventions, ensuring continuous improvement and responsiveness to the evolving needs of their personnel.

PUBLIC HEALTH IMPLICATIONS

These findings underscore the need for department specific mental health interventions especially within those where mental health preparation appears to be lacking. There is need to enhance training opportunities and address departmental culture while also promoting stigma-free access to mental health services and resources. These steps are essential to foster resilience and well-being among all first responders. There is also need for tailored strategies that consider both departmental context and gender-related perceptions to create a safer, healthier, and more supportive environment for those on the front lines of emergency response.

AUTHOR CONTRIBUTION

Atianna Caggiano graduated from the Consortium of Eastern Ohio Master of Public Health Program in May 2025. A version of this paper served as a capstone project. Caggiano's faculty preceptor, Nicolette Powe, oversaw the paper.



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APPENDIX – First Responder Mental Health Service Utilization Survey

This survey was designed to assess challenges and inform strategies related to advocacy, peer support, and organizational change to improve mental health awareness, reduce stigma, and support first responder wellness. Survey questions were developed and coded according to a theoretical framework that best aligned with each item, specifically either the Andersen Model of Health Service Utilization or the US Surgeon General's Framework for Workplace Mental Health and Well-Being.

Question	Options	Framework
1. Consent question	-----	-----
2. What is your role as a first responder?	<ul style="list-style-type: none"> •Firefighter •Police Officer •EMT/EMTI/Paramedic 	Demographic <i>Andersen Model of Health Service Utilization</i> Predisposing factors
3. What is your gender?	<ul style="list-style-type: none"> •Male •Female •Non-binary 	Demographic <i>Andersen Model of Health Service Utilization</i> Predisposing factors
4. Are you a Mahoning County first responder?	<ul style="list-style-type: none"> •Yes •No 	Demographic <i>Andersen Model of Health Service Utilization</i> Predisposing factors
5. Are you currently active or retired?	<ul style="list-style-type: none"> •Active duty •Retired 	Demographic <i>Andersen Model of Health Service Utilization</i> Predisposing factors
6. Any previous or current military service?	<ul style="list-style-type: none"> •Yes •No •Prefer not to answer 	Demographic <i>Andersen Model of Health Service Utilization</i> Predisposing factors
7. How many years have you worked at your department?	Fill in	Demographic <i>Andersen Model of Health Service Utilization</i> Predisposing factors
8. What is your current age?	Fill in	Demographic <i>Andersen Model of Health Service Utilization</i> Predisposing factors
9. What is your department type?	<ul style="list-style-type: none"> •Volunteer •Career •Combined 	Demographic <i>Andersen Model of Health Service Utilization</i> Predisposing factors
10. Response area type?	<ul style="list-style-type: none"> •Suburban •Rural •Urban •City 	Demographic <i>Andersen Model of Health Service Utilization</i> Predisposing factors
11. Employment status?	<ul style="list-style-type: none"> •Full-time •Part-time •Volunteer 	Demographic <i>Andersen Model of Health Service Utilization</i> Predisposing factors
12. How would you rate the importance of mental health support for first responders?	•1-5 not important to very important (Likert scale)	Importance <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Protection from Harm
13. To what extent do you believe mental health services are beneficial to first responders?	•1-5 not beneficial to very beneficial (Likert scale)	Belief <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Protection from Harm
14. Have you experienced a trauma related call?	<ul style="list-style-type: none"> •Yes •No •Prefer not to answer 	Trauma <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Protection from Harm <i>Andersen Model of Health Service Utilization</i> Need-Based Factors



<p>15. Have you ever responded to a call that still lives in your mind to this day?</p>	<ul style="list-style-type: none"> •Yes •No •Prefer not to answer 	<p>Trauma <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Protection from Harm <i>Andersen Model of Health Service Utilization</i> Need-Based Factors</p>
<p>16. Have you ever had an incident that kept you from sleeping?</p>	<ul style="list-style-type: none"> •Yes •No •Prefer not to answer 	<p>Trauma <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Protection from Harm <i>Andersen Model of Health Service Utilization</i> Need-Based Factors</p>
<p>17. Have you ever had an incident that has stayed in your mind for an extended period of time?</p>	<ul style="list-style-type: none"> •Yes •No •Prefer not to answer 	<p>Trauma <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Protection from Harm <i>Andersen Model of Health Service Utilization</i> Need-Based Factors</p>
<p>18. Have you developed unhealthy coping mechanisms to deal with emotional traumas (drinking, drugs, anger management)?</p>	<ul style="list-style-type: none"> •Yes •No •Prefer not to answer 	<p>Trauma <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Protection from Harm <i>Andersen Model of Health Service Utilization</i> Need-Based Factors</p>
<p>19. Are you aware of mental health services or support groups available to you as a first responder?</p>	<ul style="list-style-type: none"> •Yes •No •Prefer not to answer 	<p>Stigma <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Protection from Harm <i>Andersen Model of Health Service Utilization</i> Enabling Factors</p>
<p>20. Have you ever utilized mental health services or support groups?</p>	<ul style="list-style-type: none"> •Yes •No •Prefer not to answer 	<p>Stigma <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Protection from Harm <i>Andersen Model of Health Service Utilization</i> Enabling Factors</p>
<p>21. If you have utilized mental health services, how satisfied were you with the support you received?</p>	<ul style="list-style-type: none"> •1-5 not satisfied to very satisfied (Likert scale) 	<p>Stigma <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Protection from Harm <i>Andersen Model of Health Service Utilization</i> Enabling Factors</p>
<p>22. Do you feel that seeking mental health services could affect your job or career advancement?</p>	<ul style="list-style-type: none"> •Yes •No •Unsure •Prefer not to answer 	<p>Perception <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Connection and Community <i>Andersen Model of Health Service Utilization</i> Enabling Factors</p>
<p>23. How significant is the stigma associated among first responders, in your opinion?</p>	<ul style="list-style-type: none"> •1-5 not significant to very significant (Likert scale) 	<p>Stigma <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Connection and Community <i>Andersen Model of Health Service Utilization</i> Enabling Factors</p>



<p>24. Do you have concerns about confidentiality when using mental health services provided by your employer?</p>	<ul style="list-style-type: none"> •Yes •No •Prefer not to answer 	<p>Perception <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Protection from Harm <i>Andersen Model of Health Service Utilization</i> Enabling Factors</p>
<p>25. What types of mental health services would you find most helpful? Select all that apply.</p>	<ul style="list-style-type: none"> •One-on-one counseling •Trauma-focused therapy •Online/Telehealth •Support groups •Peer-led groups •Walk-in crisis clinics •Mobile crisis clinic •Stress management workshops •Mental health education and awareness campaigns •Pet-assisted therapy 	<p>Importance <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Protection from Harm <i>Andersen Model of Health Service Utilization</i> Enabling Factors</p>
<p>26. Have you ever received any mental health training (eg, stress management, resilience building) as part of your job?</p>	<ul style="list-style-type: none"> •Yes •No •Not sure 	<p>Culture <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Protection from Harm Opportunity for Growth</p>
<p>27. How often do you feel that your department's culture discourages seeking help for mental health issues?</p>	<ul style="list-style-type: none"> •Yes •No •Prefer not to answer 	<p>Culture <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Connection and Community <i>Andersen Model of Health Service Utilization</i> Enabling Factors</p>
<p>28. Do you think there's an unspoken expectation among first responders to "tough it out" rather than seek mental health support?</p>	<ul style="list-style-type: none"> •Yes •No •Prefer not to answer 	<p>Culture <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Connection and Community <i>Andersen Model of Health Service Utilization</i> Enabling Factors</p>
<p>29. How likely are you to trust mental health professionals with first responder-specific knowledge?</p>	<ul style="list-style-type: none"> •1-5 not likely to very likely (Likert scale) 	<p>Culture <i>Andersen Model of Health Service Utilization</i> Need-Based Factors</p>
<p>30. Have you ever avoided seeking help for mental health issues out of fear of being seen as weak?</p>	<ul style="list-style-type: none"> •Yes •No •Unsure •Prefer not to answer 	<p>Culture <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Connection and Community</p>
<p>31. How much do you feel your mental health needs are prioritized within the organization?</p>	<ul style="list-style-type: none"> •1-5 not prioritized to very prioritized (Likert scale) 	<p>Perception <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Mattering at Work</p>
<p>32. Do you believe your mental health challenges are directly tied to the nature of your work?</p>	<ul style="list-style-type: none"> •Yes •No •Unsure •Prefer not to answer 	<p>Belief <i>Andersen Model of Health Service Utilization</i> Predisposing factors</p>
<p>33. How comfortable do you feel discussing mental health issues with supervisors or peers?</p>	<ul style="list-style-type: none"> •1-5 not comfortable to very comfortable 	<p>Perception <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Connection and Community</p>



34. How often do you feel that work-related stress negatively affects your personal relationships?	•1-5 not at all to very often (Likert scale)	Perception <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Work-Life Harmony
35. To what extent do you experience feelings of isolation or detachment from family or friends due to job-related stress?	•1-5 not at all to very often (Likert scale)	Perception <i>Surgeon General's Framework for Workplace Mental Health and Well-Being</i> Work-Life Harmony
36. What barriers have prevented you from using mental health services or support groups?	Extended response	Belief <i>Andersen Model of Health Service Utilization</i> Need-Based Factors
37. What changes do you think could be made to improve access to mental health support for first responders?	Extended response	Importance <i>Andersen Model of Health Service Utilization</i> Health Outcomes and Suggestions for Improvement
38. Is there anything else you would like to share about mental health support for first responders?	Extended response	Perception <i>Andersen Model of Health Service Utilization</i> Health Outcomes and Suggestions for Improvement
39. In what ways has your mental health been impacted by traumatic incidents encountered in your role as a first responder?	Extended response	Trauma <i>Andersen Model of Health Service Utilization</i> Health Outcomes and Suggestions for Improvement
40. List of mental health support resources provided.	<p>Mental Health Resources: If you or someone you know is experiencing negative effects on mental health, support is available, please consider reaching out to the following sources:</p> <ul style="list-style-type: none"> •National Suicide Prevention Lifeline: Call or text 988 available 24/7. •Crisis Text Line: Text HOME to 741741 for free 24/7 crisis support. •Mahoning County Mental Health and Recovery Board: Visit www.mahoningmentalhealth.org or call 330-746-2959 for local resources and assistance. •Help Network of Northeast Ohio: Dial 211 for 24/7 support and referral to mental health services. •Compass Family and Community Services: Call 330-782-5664 for counseling and crisis intervention. 	<hr style="width: 10%; margin-left: 0;"/>