April 4, 2014

Mr. Harry Bains; MLA
Opposition Critic for Jobs, Labour; Employment and Worksafe BC.
Room 201, Parliament Buildings,
Victoria, BC
V8V 1X4

RE: Need for Presumption of Illness for PTSD in First Responders in BC.

Dear Mr. Bains,

I am writing this letter in support of an initiative for presumptive coverage of posttraumatic stress disorder (PTSD) for first responder personnel in British Columbia. I am a registered clinical counsellor in British Columbia who specializes in providing therapeutic support and training to this population. I also conduct scholarly research on first responders. My twelve years of experience as a police officer and public safety dispatcher also informs my work with this population and, consequently, my intimate awareness of the issues that impact first responders.

Presumptive coverage for PTSD for first responders is imperative for many reasons which I will outline here. Approval of presumptive coverage is not to be relegated to merely a "feel-good" act. There is more than two decades of scholarly research detailing the negative impact of first responder work that demonstrates the necessity for presumptive coverage. Some research is conducted within one first responder profession, while others include multiple first responder professions. Research in one profession has largely been recognized as applicable across first responder professions. Research support will be complemented by my personal and professional experience with the first responder profession.

PTSD

PTSD rates in first responders is variable, with some reports indicating that the diagnosis of PTSD in the first responder population is actually less than or equal to the general population (Canadian Mental Health Association, 2011; National Institute of Mental Health, 2010) while others demonstrate a percentage much higher than the population. PTSD rates for paramedics are the highest in the first responder profession at 22% (Bennett, et al., 2005) and 21% (Clehessy & Ehlers, 1999), police officers at 19% (West et al., 2008), and firefighters at 16.3% (Heinrichs, et al., 2005). These rates are two to three times higher than the rates of the general population. Making matters worse, PTSD contributes to increased guilt, depression, illness, job turnover, and reduced decision-making ability (Drewitz-Chesney, 2012).

Conflicting reports can be confusing for some trying to make sense of the data. There are many reasons for this variability. First, first responders typically conceal their struggles with PTSD for fear of reprisals from their employers and even their co-workers. Second, the rates of PTSD in this population are often mitigated by 1) the hardy constitutions of persons who apply for first responder employment to begin with, 2) pre-employment psychological screening that

eliminates psychologically-vulnerable persons from gaining employment, and 3) training offered by first responder organizations that assist employees in their ability to manage their exposure to trauma. Therefore, the fact that PTSD rates rise to the level of the general population is already troubling. When it exceeds this rate, which it does in many reports, it is very compelling evidence of the negative impact of the work. As a therapist and mental health columnist, I am contacted on a regular basis by first responders who are experiencing symptoms of PTSD but have not notified their employer despite its effect on their work. This is a very grave concern, as we must consider the damaging effects to the first responder and the potential harm to the citizens they serve in this compromised state.

Secondary Traumatic Stress

PTSD rates are also a very small part of the bigger picture. Secondary traumatic stress disorder (STSD) is a much larger threat to the psychological well-being of first responders. The concept of secondary traumatic stress (STS) is less well known despite its well-documented occurrence in the helping professions. The term *secondary traumatic stress* is sometimes used interchangeably with terms such as *compassion fatigue* (Figley, 1995), *vicarious traumatization* (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), *burnout, complex or cumulative stress,* and *occupational stress injury* (The Subcommittee on Veterans Affairs of the Standing Senate Committee on National Security and Defence, 2003). Whereas a singular traumatic event or series of events has happened personally to the person suffering from PTSD, STS occurs when a person in a helping profession is repeatedly exposed to the traumatization of others and develops symptoms that parallel those of PTSD. This has been documented in a variety of helping professions such as emergency room doctors and nurses, psychologists, therapists, social workers, and first responders such as firefighters, ambulance personnel, and police officers (Baird & Kracen, 2006; Collins & Long, 2003; Figley & Kleber, 1995; Salston & Figley, 2003; Simon, Pryce, Roff, & Klemmack, 2005). Police officers who repeatedly respond to trauma victims are at risk of developing STS, if not PTSD (Hafeez, 2003; Marshall, 2003; Salston & Figley, 2003). The same holds true for all other first responders. Some experts suggest that first responders who do not meet the full criteria for PTSD should be included in morbidity rates for PTSD because they are indistinguishable from those who meet full criteria (Weiss, Marmar, Schlenger, Fairbank, Jordan, Hough, & Kulka, 1992). The diagnosis for PTSD was changed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) in recognition of the impact of first responder work on individuals adding "Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures" (American Psychiatric Association, 2013). Inclusion of first responder exposure in the diagnosis criteria for PTSD demonstrates official recognition by the psychiatric community of the negative impact of the work.

A large-scale study of more than 1000 police officers indicated 33% reported intrusive thoughts, memories, or dreams about a work event, 24% felt detached from people and activities related to a stressful event, and 23% avoided anything related to an event (Gershon, et al., 2009).

Another study on cumulative traumatic stress revealed that 74% of officers reported experiencing recurring memories of an incident, 62% reported experiencing recurring thoughts or images, 54% reported avoiding reminders of an incident, and 47% reported experiencing flashbacks of an incident, 31% reported experiencing intense fear, helplessness, or horror from the job, and 11% of responding officers stated they experienced suicidal ideation as a result of the occupation (Marshall, 2003). These effects appear to be long-lasting as officers have reported having vivid visual, tactile, and olfactory memories of traumatic events lasting more than 20 years (Karlsson & Christianson, 2003). These reports are consistent with my experiences of therapy clients with PTSD.

A large-scale study of 617 active-duty paramedics demonstrated a 22% rate of PTSD (Bennett, et al., 2005). Almost half (45.8%) of the paramedics indicated ongoing troubling memories with almost two-thirds (62.4%) reporting that they have been troubled by memories of trauma in the past. These rates are quite disturbing if we consider that these are active-duty paramedics, not those who have taken leave or have left the profession. If we included those individuals as well, we would likely see a much higher percentage of PTSD.

Exposure to Routine Stress

Exposure to routine occupational stress has been found to be a stronger predictor of psychological distress, including posttraumatic stress symptoms, than cumulative exposure to critical incidents or danger (Liberman, Best, Metzler, Fagan, Weiss, & Marmar, 2002). One of the routine stresses that may contribute to PTSD is organizational stress. In fact, research indicates that organizational stress often contributes more to the development of PTSD than traumatic events (Maguen et al., 2009; Regehr & Millar, 2007).

Organizational Trauma

A triad believed to contribute to PTSD in paramedics includes 1) job exposure, 2) dysfunctional peer support, and 3) a negative attitude towards emotional expression (Lowery & Stokes, 2005). Although we cannot do much to reduce the amount of exposure on the job, we can take measures to address dysfunctional peer support and the influence of a first responder culture that promotes a negative attitude towards emotional expression. Presumptive coverage for PTSD would go a long way toward mitigating these two factors, which, in turn, would help first responders in facing their daily exposure to trauma in the course of their work.

In response to research indicating the prevalence of STS, some police departments have incorporated training aimed at helping officers identify and manage stress. Yet changes within the organization, a documented source of stress (Abdollahi, 2001; Anshel, 2000), are not forthcoming (Anderson, Litzenberger, & Plecas, 2002). Leadership that models acceptance of emotional reactions and stress as normal, even expected, given the nature of the job might send a supportive message to those troubled by STS and PTSD. First responders' responses to traumatic events must be normalized instead of hidden and avoided in order to create sustainable positive change in the workplace culture (Whitehead, 2006). This would promote an empowering culture, which, in turn, would promote resiliency in first responders facing critical incident stress (Palm et al., 2004; Paton et al. 2009).

The Way Forward

We have a moral and legal responsibility to support first responders who voluntarily expose themselves to the traumatic events in their work in service to the public. A critical first step in supporting first responders is the official recognition of the inherent risk of PTSD in first responder work. Official recognition of the deleterious effects of the work will offer two primary benefits: 1) It will legitimize an "invisible" illness, thereby validating the reality of many PTSD sufferers who are being cheated from due care and 2) it will hopefully stimulate preventation initiatives. One of the most critical initiatives we can support is preventative education.

Education

Pre-trauma education is believed to protect first responders from developing mental health distress such as STS and PTSD (Anshel, 2000; Everly & Mitchell, 2000; Meichenbaum, 2007). Education should include information about building coping strategies (Anshel, 2000; Gershon et al., 2009), stress management and healthy lifestyles as preventative measures for substance abuse (Cross & Ashley, 2004; Marshall, 2003; Stearnes & Moore, 1993), trauma-preparedness training (Karlsson & Christianson, 2003; Everly, 1995; Marshall, 2003), and stress inoculation training (Meichenbaum, 1996, 2007; Novaco, 1977). Educational support should also include first responders' families. Strong, informed families promote the well-being of first responders who, in turn, are better able to perform their duties in service of their communities.

I welcome any questions, comments, or concerns you have regarding my position on presumptive coverage for first responders. I would be happy to make myself available to further discuss this initiative.

Respectfully,

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