Chapter 17
Changing Hearts and Minds:
Getting Administrative Support for Delivery of Care

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ABSTRACT

By the nature of their occupation, first responders witness numerous traumatic events. Most of the time, their training and desire to help others allows them to respond professionally and appropriately. However, there are certain events that, for whatever reason, affect first responders in a more dramatic way, leading to emotional and behavioral changes that affect their interpersonal relationships and occupational functioning. Even if they recognize the need, first responders often are hesitant to reveal their distress and/or seek professional help to superiors, believing that they will be perceived as unfit for duty. In this chapter, the need for administrators to understand and accept the severe impact of traumatic events is discussed. Consistent with the individualized nature of traumatic responses, a tiered strategy of intervention is proposed. Finally, drawing from an occupational health perspective, a model that conceptualizes and responds to exposure to traumatic events as an occupational hazard is discussed.

INTRODUCTION

As you read this chapter, thousands of first responders are handling calls, hoping to positively impact the lives of perfect strangers who have called for help. Some of those calls will be life changing for the responder due to the intense nature of the event.

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The occupation of a first responder is first and foremost to protect the community. This is a multifaceted occupation, with physical requirements and cognitive demands, and often needing to work in challenging environmental conditions. Throughout this book, there has been significant attention to the challenges that first responders face as they go about their jobs:

- A job that most people cannot do.
- A job that requires individuals to tolerate what is intolerable to others.
- A job that provides a front row seat for some of life's ugliest moments (i.e., overexposure to violence, death, extreme physical injury and life or death decision making).

Although, for the most part, first responders cope with their jobs well, there should never be any underestimation of the emotional toll that this constant exposure to traumatic events can take on someone. The effects of this cumulative stress can create a breaking point. Then, there are those events from which no one should just be able to walk away: The mass shootings that result in dozens of lives lost, the child who drowns in the family swimming pool, the horrific car accident where one of the victims is a first responder's family member or friend. As one first responder shared, "I'm retiring. I've seen one too many homicides, one too many suicides, one too many car wrecks."

BACKGROUND

First responders are exposed to traumatic events and stressors on a regular basis (Substance Abuse and Mental Health Services Administration, 2018). Not every event produces traumatic stress, and it is often not possible to predict which event will be "the one." Among 215 first responders requesting treatment at a University of Central Florida Posttraumatic Stress Disorder treatment clinic (UCF RESTORES), the traumatic events that precipitated the request for treatment are presented in Table 1.

Despite the type of event, the cumulative nature of exposure to trauma can result in high rates of depression, substance abuse, acute stress disorder, posttraumatic stress disorder (PTSD), and suicidal ideation/suicide. As to the latter, each year, more firefighters and law enforcement officers commit suicide than are killed in the line of duty (Heyman, Dill, & Douglas, 2018).

First responder suicides are serious events, and, in some cases, one suicide can give permission to others to do the same. A study of police officers in New York City (O'Neill, 2001) revealed that the mixture of a failed relationship, alcohol consumption, and accessibility of firearms was a deadly combination. When suicides occur, urging from upper level administrations to "ask for help" is common; yet, many first responders worry that admitting that they are experiencing emotional distress leaves them open to judgment by peers (can they be trusted to have their partner's back?), judgment by administration that could lead to negative career repercussions (should they be taken off the road because they may be a liability?) and self-doubt (can I trust myself to react).

Table 1. Types of traumatic event that precipitated a request for treatment

Traumatic Event	Percentage
Pediatric call	22%
Mass shooting	16%
Multiple events	13%
Death of family member or friend	11%
Motor vehicle accident with death	10%
Gory/graphic/dramatic death	8%
Near death experience	7%
Shooting	6%
Suicide calls	4%
Trauma not related to work	4%
Trauma during military service	3%
Sexual assault	1%

What is necessary is not an isolated response in a time of crisis, but a continuous recognition of the stressful nature of these occupations. In other words:

- First responders are equipped with a myriad of tools, techniques, and training to handle the physical aspects of the jobs.
- However, the protective gear does not protect them from the emotional distress as a result of dealing with traumatic events.
- Past culture encouraged a "suck it up, buttercup" environment. "You knew what you were getting into."
- It is time to bring the emotional impact of these jobs out of the shadows.
- Administrators must create an environment that allows that, while first responders protect, serve, and care for others as part of the profession, the same approach exists for those who are part of this profession.

PROMOTING A BEHAVIORAL HEALTH ASSISTANCE PROGRAM

Despite the acknowledgment that first responders are constantly exposed to traumatic events the general public seldom witnesses, attitudinal barriers often prevent someone from seeking help. One attitudinal barrier is the misconceptualization regarding the goal of a comprehensive behavioral health program, which is to return the first responder to full duty. However, in order for such a program to be effective, all of the elements should be in place in advance, not after someone steps forward and asks for help. First, it is important that the agency be able to provide a professional contact to make a competent assessment of the first responder's needs. When perceived favorably by personnel, this individual may be part of an Employee Assistance Program (EAP) or a private, culturally competent practitioner. An alternative contact to the agency's EAP is strongly recommended, in cases where feedback from first responders

suggests that they are reluctant to trust, and therefore contact, the EAP. This person should also be able to provide any needed referrals. Second, although expertise in treating trauma is key, not every employee exhibiting impairment will be in need of treatment for PTSD. First responders are people and, in addition to trauma, face the same life challenges as every other member of the community. Thus, this individual and any referral sources should be able to provide counseling for common family and parenting issues as well as marital and relationships problems. Third, the agency must be prepared to deal quickly and effectively with stressors and issues that pose immediate difficulties for the first responder. This last point relates to crisis intervention and may require the need for individuals specifically trained in critical incident stress management (CISM) or psychological first aid.

The most effective Behavioral Health Assistance Programs have levels of intervention that are deployed consistently with the first responders' need. These different groups may operate independently or, in the case of a mass violence event, may be deployed simultaneously, and first responders in need are triaged based upon their response to the trauma.

Paraprofessional Services

One level of intervention is specialty trained peers. At most agencies, these peers are known as CISM teams. CISM is a procedure which is developed specifically to assist first responders who deal with a critical incident event. The goals of the CISM team are defusing and/or debriefing. Defusing is a short intervention that occurs typically within 24 hours of an event. Its goal is to allow people who are involved in the incident to learn about stress reactions and discuss their emotions. Debriefing is a more structured version of the same process and is typically conducted by a team of peers and professionals, again typically within 24-72 hours after the event. Defusing and debriefing are conducted separately, one session each with the goal of stabilization.

Other peer support teams represent a more extensive approach to stress management that can be called out during a critical incident or to deal with ongoing stressors first responders face. The idea behind peer support is that individuals in the military or first responder profession are very reluctant to seek treatment from a behavioral health professional or to reveal a mental health challenge, out of concern that doing so could be the end to a career. They are more likely to speak to peers who have similar experiences, background, and history. However, even here, there are concerns about confidentiality when the trained peer is part of the agency's peer support team. Unless there is an agreement with the agency, that conversations with a peer support team member are considered confidential, individuals in distress may be reluctant to be completely honest because the agency may require the team member to reveal shared information based on concerns about liability.

One peer support training program, which is known as REACT (Recognize, Evaluate, Advocate, Coordinate, and Track) (Marks et al., 2017), trains peers how to identify signs of stress and distress in their peers. Additionally, REACT teaches how to deliver emotional support, how to ask the difficult questions ("Are you thinking about hurting yourself?"), and how to effectively respond to the answers they receive ("Yeah, they are all better off without me"). Finally, peers who are trained in REACT learn when and how to reach out, and how to function as a resource for first responders and their families using the following training modules:

- Provide a mental schema for diagnosable disorders and familiarize attendees with available treatment options.
- Identify stress injuries.
- Initiate and maintain conversations and motivate peers to follow through with help-seeking behaviors.
- Facilitate acute stress management, including anger management and cognitive restructuring principles.

Throughout the workshop, it is repeatedly stressed that this training is not designed to train peers to diagnose or treat mental health disorders, but to recognize signs and assist peers in finding the appropriate remedies. Finally, in addition to providing support during and after traumatic events that result from work-related events, peer support teams can provide the first level of support for first responders experiencing personal and work-related stress.

Peer support and CISM teams are popular programs, but often face administrative concerns about agency liability, if the peer is acting as a therapist and concerns about "hiding" an impaired employee from superiors. These concerns are not always easy to overcome, although careful explanation and the high success rate of peer support teams to get impaired first responders into treatment will often assuage administrative fears.

Chaplaincy Programs

A second level of intervention are chaplaincy/spiritual programs. Originally used for department ceremonies or hospital visits, these individuals can be used for crisis response, if they are trained appropriately, and as members of peer support teams. Most individuals in the chaplaincy program are also employed as first responders, again allowing them to bridge the "culture gap" that sometimes plagues therapists or behavioral health specialists who do not understand the challenges and stressors of the profession. Disclosures to a chaplain (by the nature of their profession) are considered confidential, providing assurance that information will not be shared with administration.

Behavioral Health Professionals

The third level of intervention involves the use of behavioral health professionals (i.e., trained and licensed psychologists, social workers, mental health counselors, or psychiatrists who can provide intensive treatment). An important consideration is that the referral should be to a clinician who is experienced in the treatment of first responders–both in terms of understanding the culture and in treating the traumatic experiences that will be discussed. This is not always the therapist whose office is physically closest to their residence or place of work. Many first responders tell stories of finally asking for help and then being "fired" by the therapist, who revealed that the events the first responder described were "too traumatizing" for the therapist. This lack of cultural competency and the ability to hear and work with the traumas that first responders describe presents a major barrier to finding appropriate care. Administrators need to understand that not all therapists have the necessary therapeutic skills and to assist their agency in securing appropriate therapeutic resources.

In order to address this need for cultural competence, the Florida Firefighters Safety and Health Collaborative (www.floridafirefightersafety.org) has developed a two-day immersion course for mental health clinicians. This course is designed to teach firefighter culture and allow clinicians to more effectively treat firefighters. The two-day course includes the following topics and activities:

- Four hours of didactics on topics such as firefighter lingo, rescuer personality, firefighter family, retirees, and behavioral health challenges brought on by traumatic stress.
- Four hours of simulated firefighting in bunker gear, including live fire and smoke drill simulation.
- Four hours of fire station visits to understand the fire station layout and a typical day, and see the response to a call.
- Four hours of discussions of traumatic events firefighters have faced and facilitation of discussion.

In addition to the two-day course, clinicians must complete 10 hours of ride time at a fire rescue department. If it is successfully completed, the clinicians are included in a database (which is administered by the Florid Firefighters Safety and Health Collaborative) of culturally competent therapists. According to the collaborative, these courses have been very popular across the state of Florida and, hopefully, will lead to therapists who are better able to understand and assist firefighters seeking behavioral health treatment. Should this program prove successful, as determined by an increase in the number of culturally competent therapists delivering evidence-based treatments with positive therapeutic outcomes, these classes could serve as a model for cultural training for other first responders.

A COMPREHENSIVE STANDARD OF CARE FOR FIRST RESPONDERS

The types of intervention represent only the first steps to get administrative support for addressing the traumatic effects of stress in first responders. They all represent actions that should be taken after the traumatic injury has occurred. As the recognition of the potential long-term psychological impact upon the career of first responders becomes more apparent, several states have passed legislation to include a primary diagnosis of PTSD as a recognized condition that must be addressed by Workman's Compensation. Standard of care is defined as the "degree of care (watchfulness, attention, caution, and prudence) that a reasonable person should exercise under the circumstances. Individuals who do not meet the standard of care could be liable for negligence" ("Standard of care," 2019). To date, no recognized standard of care exists for the treatment of PTSD in first responders. The subsection below presents the critical components of a comprehensive standard of care.

Necessary Attitudes for Implementing a Standard of Care

This chapter is subtitled *Getting Administrative Support for Delivery of Care* because, without support at the administrative level, first responders will continue to hide in the shadows (or be hidden by their colleagues), believing that requesting treatment for PTSD and other trauma disorders will be the end of their career. Thus, hearing from the administration that "it's OK to ask for help" is an important attitude that must be communicated from the top level of the administration, but there is a need for more than simple worlds. One approach toward prevention of suicide among police officers could be easily adapted to deal more broadly with first responder mental health. The approach, based on an occupational-health

assessment protocol (Fein, 1998, cited in Amsel, Placidi, Hendin, O'Neill, & Mann, 2001), begins by acknowledging that traumatic stress is an occupational hazard for first responders. The next subsection analyzes the specific steps to implement this occupational health model and the required resources to do so. However, prior to that discussion, other basic attitudinal changes are necessary.

Administrators are charged with responsibility for running operations and being aware of what is happening within their command. This responsibility often clashes with the need for confidentiality. In fact, maintaining confidentiality is key to first responders deciding to seek treatment. Although for administrative and manpower purposes supervisors may need to know that someone needs time off from work to attend appointments, the specifics of the problem do not need to be shared. The exception is when the first responder is in danger of harming him/herself or another person. Then, supervisors, and in fact anyone aware of such a threat, must act. A voluntary commitment is always preferable, but, at times, involuntary evaluation and treatment may be necessary. Again, preparation and forethought are critical. First responders take others to the emergency room all the time, meaning that they are known at mental health receiving facilities. Having a standing arrangement with a mental health service facility in another jurisdiction or county (where the first responder is not known) can prevent embarrassment or anger, when it is the first responder who is escorted by police officers into an emergency room because of the need for involuntary hospitalization.

Often, supervisors (i.e., chief, sheriff, or lieutenant) are unwilling to give up the control or uncomfortable with not knowing the details of the first responder's mental health treatment. It is important to train a supervisor as well as the team, and give them the necessary tools, directions, and discretion to carry out their assignment. Certainly, supervisors must hold the team accountable, but only the team supervisors should be aware of the nature and reason for intervention. The goal is to get first responders (any department's most valuable assets) the help that they need to perform at optimal level and provide the needed community service. These conversations need to involve human resources, employee assistance program personnel, worker's compensation carriers, legal offices, and government officials.

Undoubtedly, providing this level of care and maintaining a "hands-off" attitude is easier in smaller municipalities than it is in larger districts or major cities, where there is more media scrutiny when something "goes wrong." Similarly, situations become more complicated when employees are represented by a union. Despite the intricacies that are involved in any particular department, the overall goal remains the same (i.e., creating an atmosphere where a first responder can step forward and ask for help as the result of traumatic experiences), whether a singular horrific incidence or the cumulative effect of years of responding to community events occurs.

A Comprehensive Model for Building a First Responder Standard of Care

Returning to the idea of traumatic stress as an occupational hazard for first responders, below, the authors detail a protocol for the implementation of occupational-health assessment, modified for mental health (Amsel et al., 2001; Kahn 1993, cited in Amsel et al., 2001):

1. Identify a health problem with an elevated incidence in the occupation.
2. Identify the risk factors for the problem.
3. Identify which of the established risk factors has elevated exposure in the population.
4. Modify work processes to reduce exposure to the hazard, where possible.
5. Introduce protective factors.

6. Monitor and treat sequelae of exposure.

Identify a Health Problem

At least 20 years of evidence show that more first responders die as a result of suicide than in the line of duty. Although the primary reason for suicide in police officers appears to be failed relationships, the reasons for the failed relationships may be varied, but certainly includes PTSD in the first responder. With mass violence events such as 9/11/2001 and mass shootings in communities across the nation, there is now general acknowledgement that "stuff it away" is no longer appropriate and that traumatic stress responses represent an occupational health problem.

Identify Risk Factors for the Problem

As defined by the *Diagnostic and Statistical Manual of Mental Disorders (5th edition)* (American Psychiatric Association, 2013), the onset PTSD and other trauma-related disorders is the existence of a traumatic event. Thus, traumatic events represent the primary risk factor. Other factors include family and personal history, prior exposure to traumatic events, economic factors, and other personal risk factors, such as sex.

Identify Which of the Established Risk Factors Has Elevated Exposure in the Population

Exposure to a traumatic event, such as witnessing the violent death or severe bodily injury of another person, is an unlikely event for most individuals, perhaps occurring once or twice in a lifetime. For others, such as those in the military and first responders, it is a common and, for some first responders, almost daily event. Thus, the primary risk factor for traumatic stress is one to which first responders are exposed to repeatedly. This heightens their risk for negative emotional responses, which can include, but are not necessarily limited to, PTSD.

Modify Work Processes to Reduce Exposure to the Hazard Where Possible

It is unlikely that the nature of the work of the first responder allows the modification of work processes to reduce exposure to traumatic events. First responders who seek treatment do not want to return to a "desk job." They want to return to full duty. Although a standard of care should carefully examine procedures and best practices that might lower the risk of exposure, more effort should be spent introducing protective factors and monitoring and treating the sequelae of exposure.

Introduce Protective Factors

The first responder community can take a myriad of actions to serve as protective factors. First, the topics of trauma, traumatic stress, the aftermath of trauma, resiliency, and the various behavioral and emotional disorders that can result from trauma should be an integral part of every recruit's training. The introduction of these topics prior to beginning the actual job will not inoculate someone against the effects of trauma, but, when the new recruit does have a "bad call" and is feeling typical posttraumatic

stress, the recruit may at least recall that such effects are common after such an event and do not indicate weakness. Education about these issues should also be part of any family orientation that occurs at this time. Additionally, continuing education of all officers regarding, for example, mental health topics, the biology of trauma, stress and stress management, sleep hygiene, anger management, interpersonal relationships, and financial stressors would be a potential potent protective factor. To date, no agreed-upon standardized or even "sample" curriculum are available, even though such standards would be welcomed by the field.

Although education is an important first step, a successful standard of care cannot end there. CISM and peer support teams are another type of protective factor that contribute to a complete standard of care. Earlier in this chapter, the authors noted the composition and purpose of CISM teams (i.e., defusings and debriefings). Defusings are conducted as brief conversations by the team to assess, triage and mitigate symptoms and occur within hours after a critical incident. Debriefings use a 7-phase model, are more in depth and occur up to 10 days out from incident and even later if the incident involved large numbers of responders (Sept. 11th is a good example). Good practice among CISM teams will include a licensed mental health professional, in order to assure confidentiality of the discussions. It is critical that, while attendance in these defusings and debriefings may be mandatory, speaking in the sessions must always be voluntary. Forcing people to speak during these meetings has been demonstrated to create psychological harm.

Peer support teams fulfill many functions as CISM teams, but often also function in situations outside of a critical incident. Not all administrations embrace peer support programs, but, when there is administrative support, peer support becomes a critical part of first responder culture. Peer support is useful when first responders have limited opportunities to access formal mental health treatment or when first responders have concerns about the stigma or negative changes in job duties or pay should they engage in mental health treatment. Data suggest that first responders who receive early regular peer support report (a) significant gains in cognitive functioning, (b) improved social and over all functioning, and (c) decrease in psychiatric symptoms (e.g., Repper &Carter, 2011).

Finally, prevention may include an overall focus on general wellness and well-being. Having easy access to gym facilities, educational classes/workshops on health topics, wellness tips delivered via email or text, and health fairs are examples of methods to promote wellness, decrease stress, and reduce vulnerability to traumatic stress. If administrators lead by example and encourage the use of these opportunities, that culture of "taking care of our own" will permeate through the agency.

Monitor and Treat Sequelae of Exposure

Not everyone responds to trauma in the same fashion. It is a mistake to assume that, after even the most horrific mass casualty event, *everyone* will develop PTSD or that *no one* will develop PTSD. Part of developing a standard of care is acknowledging that not everyone reacts to an event in the same fashion, and that immediately rushing in to provide treatment can create more damage than good. In some individuals, temporary symptoms may be present immediately after an event, but decrease over a period of weeks. In instances where many members of a department may be impacted by the same traumatic event, establishing a voluntary monitoring program over 30 to 60 days will help determine those whose symptoms are remitting vs. those whose symptoms are stable or worsening.

However, there comes a time when even the best education and prevention strategies are not enough to prevent the onset of behavioral health disorders such as depression, anxiety, PTSD, or substance abuse. Various appropriate treatment options exist. The key is finding therapists who are culturally competent and use evidence-based interventions.

FUTURE DIRECTIONS

As the number of states who consider PTSD as a workman's compensation issue continues to grow, to date, there is minimal vetting of potential providers by Employee Assistance Programs, who typically accept a therapist's self-declaration as "experienced in treating trauma." Unfortunately, many therapists who claim that distinction have had no experience with either first responder culture or the type of traumas that they experience. As the authors noted above, first responders often describe being "fired" as patients by therapists who indicate that the traumas the first responders revealed were too upsetting for the therapist to handle. Given the reluctance of most first responders to seek treatment, having a bad experience with an ill-prepared and improperly trained therapist will discourage many of them from seeking further treatment. Thus, imperative for any standard of care are clinicians who have been trained and certified as culturally competent (i.e., they understand first responder culture) and well-versed in evidence-based treatments for trauma disorders. Cultivating such therapists will require collaboration between the first responders community and university-based training clinics.

CONCLUSION

This chapter addressed the issues and challenges in implementing behavioral health programs for first responders, especially getting substantive support from departmental administrations. Support is more than just a statement that "It is ok to not be ok." It requires the establishment and support of programs that are put in place with initial training and continue throughout the life of the first responder, including first responders who have retired. The authors hope that this chapter will motivate others to work with the administrative arms of their organizations to develop a comprehensive standard of care to address the psychological occupational hazards that are an integral part of the career of a first responder.

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KEY TERMS AND DEFINITIONS

Behavioral Health: A field of study that examines how emotions and behavior affect psychological and physical well-being.

Cultural Competence: In healthcare, it is the ability to deliver care to someone with an understanding of their unique perspective, values, and needs.

First Responder: An individual uniquely trained and responsible for going to a place where there is a need for emergency assistance.

Occupational Health Assessment: An examination conducted by a professional to determine environmental adjustments that might be made to promote a healthy working environment.

Peer Support: The use of specially trained individuals to provide emotional and behavioral support to their colleagues.

Standard of Care: A process, procedure, or course of treatment that clinicians follow and that is accepted as an appropriate approach by their professional community.

Trauma: An experience that creates deep emotional distress for an individual.