First Responders
TRAUMA INTERVENTION and SUICIDE PREVENTION

Suicide Prevention Resource Toolkit

CENTRE FOR SUICIDE PREVENTION

INTRODUCTION

First responders—paramedics, firefighters, police, corrections officers—are considered to be at greater risk for **Acute Stress Disorder (ASD**) and **Post Traumatic Stress Disorder (PTSD)** than most other occupations. This is because their everyday duties routinely encounter "traumatic stressors" (Haugen, 2012, p.370).

Some researchers believe that experiencing PTSD is also a high-risk factor for subsequent suicidal behaviours (Sareen, et al., 2007).

Military suicides related to PTSD have been covered extensively by the media in recent years. The coverage of suicides and stress-related disorders among first responders has been much less (Canadian Association of Chiefs of Police, 2014).

However, suicides by paramedics, firefighters, and police are now beginning to get necessary attention: Ken Barker was a retired RCMP officer who took his life in the summer of 2014 after responding to one of Canada's most gruesome murders: the 2009 Greyhound bus beheading. His death shows how vulnerable first responders can be and how lingering the effects of PTSD are: http://bit.ly/mountiesuicide

A more recent story details the ongoing first responder suicide crisis into 2015: http://bit.ly/paramedicdeath

In January 2015, 4 first responders died by suicide in Canada

CANADIAN FACTS and FIGURES

- **9.2%** of Canadians will experience PTSD in their lifetime (Van Amerigen, 2008)
- First responders experience PTSD **2** times the rate of the average population
- An estimated **22%** of all paramedics will develop PTSD (Drewitz-Chesney, 2012)
- **16** active and **15** retired RCMP officers died by suicide between **2006** and **2014**
- Between April and December **2014**, **27** first responders died by suicide
- In January, 2015, **4** first responders died by suicide (Tema Conter, 2015)

Acute Stress Disorder (ASD) and Post Traumatic Stress Disorder (PTSD)

First responders are at high risk of experiencing both ASD and PTSD as a result of frequent exposure to traumatic events:

- Paramedics have the highest rate of PTSD among first responders (Drewitz-Chesney, 2012)
- There is a high co-occurrence of PTSD, Substance Use Disorder (SUD) and Major Depressive Disorder (MDD) among first responders which further heightens risk for suicidal behaviours (Van Amerigen, 2008)

Events that can cause a traumatic experience include:

- Exposure to actual or threatened death
- Serious injury
- Sexual violation

ASD and PTSD symptoms and behaviours:

- **Dissociation from the self**
  - Emotional numbing
  - Reduced awareness of one's surroundings
  - Depersonalization
  - Amnesia
- **Re-experiencing** the traumatic event (spontaneous memories; flashbacks)
- **Avoiding** distressing thoughts, feelings, or external reminders of the event
- **Blaming** self or others due to distorted sense of reality

- **Loss of interest** in activities
- **Inability to remember** key aspects of the traumatic event
- **Aggressive**, reckless, or self-destructive behaviour
- **Sleep disturbances**
- **Hyper-vigilance**

Diagnosis Timeline:

- ASD can be diagnosed up to 4 weeks after a traumatic event
- If ASD symptoms exceed one month, a clinical assessment for PTSD is needed
- PTSD can be diagnosed after a minimum of 4 weeks. (Halpern, 2011; American Psychiatric Association, 2013)

Compassion Fatigue And Burnout

Compassion Fatigue is another reaction to a traumatic experience**.** It mirrors some of the symptoms of PTSD, but not all. Compassion fatigue can lead not only to **poor job performance**, but also to **depression, excessive drinking**, and **flashbacks** to the traumatic incident (Cacciatore, 2011).

Burnout Syndrome is also commonly experienced by first responders and is defined as a combination of "overwhelming exhaustion, feelings of cynicism and detachment to the job, and a sense of ineffectiveness and lack of accomplishment" (Cigognani, 2009, p.450). This can result from work-related operational stressors over extended periods of time and is not the result of a single incident.

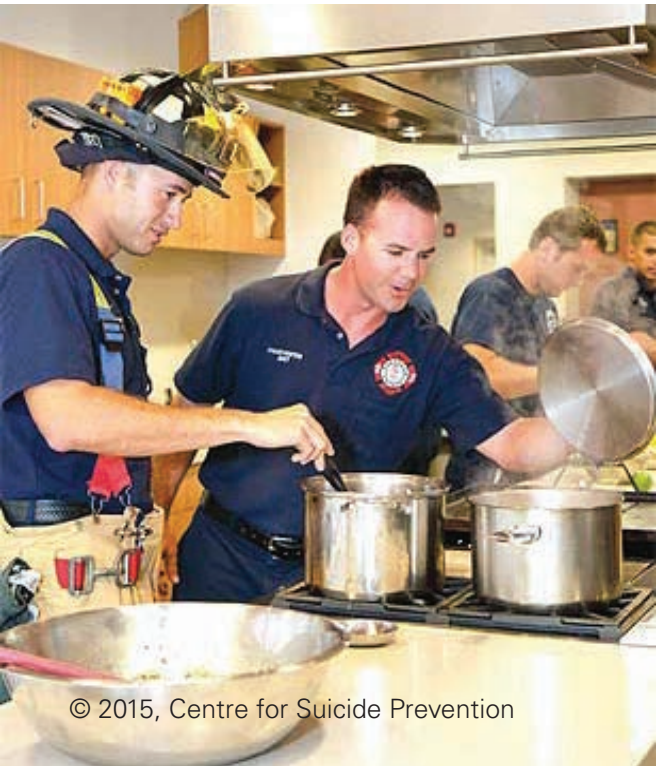
RISK FACTORS and WARNING SIGNS for Trauma

- **Exposure to incidents** that put the first responder or those around him/her at risk for death or severe injury
- **Witnessing** or participating in incidents where rescue involves preventing death or mitigating serious or severe injury
- **Social isolation**
- **Reluctance** to seek help due to fear of stigmatization
- **Failure** to recognize symptoms
- **Anger** or guilt related to patient deaths or disabilities
- **Lack of empathy**
- **Substance abuse**
- **Numbed emotions**
- **Suicidal behaviours**

(Haugen, 2012; Van Amerigen, 2008; Halpern, 2011; Drewitz-Chesney, 2012)

PROTECTIVE and RESILIENCY FACTORS against Trauma

- **Sense of community**: feelings of belonging and emotional attachment
- **Collective efficacy:** perception of the group's ability to accomplish its major tasks (first responders' jobs are highly collaborative in nature)
- **Self-efficacy:** ability to exercise some measure of control over environment
- **Positive coping strategies**: ability to manage stress constructively, such as using approaches like Cognitive Behavioural Therapy (CBT)
- **Compassion satisfaction**: positive feelings from helping others; incorporation of positive aspects of trauma situations to achieve good outcomes-"post traumatic growth" (Pietroni and Prati, 2008; Cicognani, 2009)



EXCERPT FROM iE13

iE: infoEXCHANGE

Trauma Informed Care:
Trauma, Substance Abuse and Suicide Prevention

By Robert Olson, Librarian and Writer,
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Mental health professionals tell us that both the severity of trauma that some people experience and the number of trauma survivors is much greater than most people realize. In fact, the majority of clients who end up in human services systems are trauma survivors (Elliott, 2005).

One in ten Canadians has experienced trauma in some form; **sexual abuse, physical abuse by caregivers, exposure to war, suicidal loss, homicidal loss,** and **accidents** are just a few of the many risk factors for trauma (Klinic, 2013). Many victims will process the traumatic events, recover to a certain degree, and successfully move on with their lives.

Resiliency can be a powerful human characteristic. Many others are not so fortunate and, thus, will deal with their traumatic experiences in any way possible.

Trauma has been defined as "A horrific event beyond the scope of normal human experience" (Greenwald, 2007, p.7). A person who experiences a traumatic event may feel like their life has been threatened. They may also have feelings of **helplessness,** along with **horror**, **fear,** or **disgust** (Greenwald, 2007).

The typical symptoms of someone suffering traumatic distress include **re-experiencing the event, avoidance and emotional numbing, changes in sleeping patterns, and hyperarousal** (Huckshorn, 2013).

Additionally, trauma can cause co-occurring disorders such as **substance use disorder**. In these cases, the trauma victim abuses alcohol or drugs in an attempt to numb the pain caused by the memory of the trauma. When co-occurring disorders combine with other illnesses - depression, for example - they

Symptoms of someone suffering traumatic distress include re-experiencing the event, avoidance and emotional numbing, changes in sleeping patterns, and hyperarousal.

can make an individual more susceptible to suicidal ideation or suicidal actions.

...researchers of one study have suggested that, historically in mental health, two assessment factors have contributed to the neglect of trauma concerns. One is the **under-reporting of trauma** by survivors due to a lack of trust, a fear of being stigmatized, or by a failure to recognize the symptoms of trauma by the survivors themselves. The second factor is the **under-recognition of trauma,** or a lack of awareness of traumatic symptoms by health care providers (Harris, 2001).

To read the full article, click here: http://bit.ly/iE13Trauma

TRAUMA INTERVENTION

Critical Incidents

A critical incident is "any event that has a stressful impact significant enough to overwhelm an individual's sense of control, connection and meaning in his/her life" (Cicogani, 2009, p.450).

Examples of critical incidents that a first responder may encounter include:

- **Death of a coworker**
- **Natural disasters**
- **Experiences with sick or dead children, and**
- **Death of a citizen** (Sanford, 2003).

Critical Incident Stress Debriefing (CISD)

The traumatic intervention tool that is used most often in Canadian emergency services, fire departments and police services is called **Critical Incident Stress Debriefing (CISD).** It is a "7-phase, small group supportive crisis intervention process" (Mitchell, n.d., p.1).

CISD is one of the facets which comprise the **Critical Incident Stress Management (CISM)** approach. A CISD is only used in the aftermath of a significant traumatic event that has adversely affected individuals. The objectives of the debriefing process are to:

- deflate the impact of a traumatic incident,
- facilitate and restore recovery, and
- identify group members who need further psychological support.

It is a small group process—"psychological first aid"—which strives for a "restoration of group cohesion and unit performance" (Mitchell, n.d., p.1) following a traumatic episode. It aims to foster recovery by encouraging a group dialogue. Ideally, the CISD team is comprised of a mental health professional (acting as facilitator) and peer support volunteers.

Advocates of CISD believe that exposure to traumatic stressors cause a substantial number of individuals to experience major psychological problems. If intervention is received shortly following exposure, the prevention of the onset of PTSD symptoms will improve. If symptoms do occur, CISD will speed up the person's recovery (Mitchell, n.d.).

One report addressing the lack of a debriefing protocol within the police department of Allen Park, Michigan, addressed the

efficacy of CISD. It stated that **debriefings were crucial for traumatized first responders, as they will reinforce feelings of support, hope and sense of control**—all of which are " necessary to recover from a critical situation" (Sanford, 2003, p.22) and that CISD is the preferred method.

A meta-analysis by Everly and Boyd (1999) concluded the CISD model of psychological debriefing is an effective crisis intervention.

Supporters of CISD believe it to be an effective intervention provided that 2 crucial criteria are met:

1. **Personnel have been properly trained in all aspects of Critical Intervention Stress Management (CISM)** and
2. **Providers are adhering to internationally accepted standards of CISM practice** (Mitchell, n.d.,p.6).

Criticisms of CISD:

- CISD does not directly address other mental health issues which may arise for trauma victims, such as depression or other psychological problems,
- There are concerns that CISD providers may unintentionally influence participants into a "pre-existing idea of a correct state of emotional responding" (Jeanette and Scoboria, 2008, p.315), and
- CISD is an affront to first responders' sense of themselves as an effective group, particularly when offered by individuals or agencies **outside** the group (Jeanette and Scoboria, 2008).

PEER SUPPORT: AN INTERVENTION SUCCESS STORY

Sgt. Sergio Falzi is a long-time officer with the **Calgary Police Service** (CPS). He helped develop and implement the Peer Support Network with CPS. The network is relationship-based, consisting solely of volunteer officers who have experienced trauma or other work-related stresses. They provide support for other officers in need of help. The program offers both short and long-term assistance. Over 80% of participants take the initiative to seek help on their own. Only 10% are referred by superiors or others.

The following is a short interview conducted by the Centre for Suicide Prevention with Falzi:

Can you please describe the peer support program for officers?

The peer support program is a relationship-based supportive network. Volunteer officers work both formally and informally to assist fellow officers address work-related stresses, responses to crises, and any mental health issues they might have.

How long has Calgary Police Service had the program and how did it come into being?

The peer support program came into existence in 1998. It was formed by officers who felt there needed to be a more formalized program to address crises and traumatic experiences that officers may encounter on a daily basis.

Can you tell us about a few 'successes'?

Sure. Our model, or variations of it, have been adopted by several police forces. We were also positively cited by the Ombudsman of the Ontario Provincial Police as a model support program. The program has become a fixture of Calgary Police policy and an important part of Calgary Police culture and the larger psychological services we provide our members.

How do other officers respond to the Peer Support Officer?

They are very accepting of them. The program and its volunteer officers have become normalized. Their work has done much to de-stigmatize trauma and mental illness and to help prevent suicide. I think overall the peer support volunteers are positively viewed and accepted among the officer rank and file.

Do you see the Peer Support program as a useful vehicle to process stress, debrief traumatic events, reduce suicides?

There are currently 64 members who are peer-support volunteers. All officer volunteers have "lived experience" with trauma in some way or other. This adds an extra element to the "peer" approach. These are not only fellow police officers but officers who have "been there" and who know how to help others having similar experiences.

ADDITIONAL RESOURCES

Badge of Life Canada
http://badgeoflifecanada.com/
An organization and website for PTSD and trauma survivors

Heroes Are Human: The Tema Conter Memorial Trust http://www.tema.ca/
A website which is "a hub of research, training and education dealing with PTSD and operational stress injuries".

Living Life to the Full
http://www.llttf.ca/about-the-course/
A national, flagship program of the Canadian Mental Health Association (CMHA).

Mental Health First Aid http://www.mentalhealthcommission.ca/English/initiatives-and-projects/mental-health-first-aid
A program designed to help individuals identify and manage mental health problems in themselves and others.

Mental Health Works
http://www.mentalhealthworks.ca/
Mental Health Works is a national program of the Canadian Mental Health Association (CMHA) that builds capacity within Canadian workplaces to effectively address the many issues related to mental health in the workplace.

North American Fire Fighter Veteran Network http://firefighterveteran.com/
A resource website and crisis line for fire fighters and other first responders experiencing mental health issues.

Paramedics Chiefs of Canada report on operational stress injury http://paramedic.ca/wp-content/uploads/2014/08/PCC-Ad-hoc-Committee-on-Stress-Injury-Report.pdf

Road to Mental Readiness
http://www.mentalhealthcommission.ca/English/system/files/private/document/1%2520PG%2520R2MR%2520Police%2520Backgrounder%2520ENG_0.PDF
A training program designed to reduce stigma and increase resiliency in police employees.

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