



JACK, JOSEPH AND MORTON MANDEL
SCHOOL OF APPLIED SOCIAL SCIENCES

CASE WESTERN RESERVE
UNIVERSITY

Begun Center for Violence Prevention
Research and Education

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RE: HB 308 under consideration by the Senate General Government and Agency Review

Committee

Dear Chairman Schuring, Vice Chair Ruilli, and Ranking Member O'Brien:

I would like to submit the below written testimony in support of your consideration of HB 308 as presented by Representative Patton and in particular the recommendation to provide medical coverage for first responders who have been formally diagnosed with Post Traumatic Stress Disorder (PTSD).

Every day over 200,000 Ohio men and women start their work day expecting the unexpected. This is especially true given recent challenges brought on by the heroin-opiate overdose crisis and the COVID-19 pandemic. Our police officers, firefighters and EMS workers are always there for us, willing to protect and serve, yet never knowing what their day will bring including often dangerous and potentially life threatening situations.

When most of us think about what these first responders might face, our thoughts generally turn to the physical dangers of the job. And yet those 200,000 first responders face another type of potential emotional injury, most often invisible, called **Post Traumatic Stress Disorder**.

Currently I am the Dr. Semi J. and Ruth Begun Professor and Director of the Begun Center for Violence Prevention, Research and Education at the Jack, Joseph and Morton Mandel School of Applied Social Sciences at Case Western Reserve University in Cleveland, Ohio. I am a licensed clinical psychologist with over twenty five years of experience conducting research on violence and mental health. I have conducted therapy for individuals with PTSD. For the past 20 years I have regularly worked with law enforcement and first responders at the local and federal levels conducting trainings, participating in ride-alongs and collaborating on evidence-based interventions including for example the Fugitive Safe Surrender program, community-

based policing efforts, gang prevention, offender reentry and intelligence-led policing for effective interdiction. I hold faculty appointments in the departments of Psychiatry and Pediatrics at Case Western Reserve University and in the graduate school at the University of Notre Dame. I regularly consult with the US Departments of Justice, Education, and the Substance Abuse and Mental Health Services Administration on issues related to mental health and trauma.

We at the Begun Center at CWRU, housed in the graduate school of Social Work, engage in community-based research in the areas of violence prevention, treatment services, trauma, exposure to violence, mental health, and community based prevention and intervention programs. Much of the work we do is in developing, identifying, implementing and evaluating data driven, and cost effective approaches to working with some of our state's most challenging youth and adult populations.

Our team of clinicians and scientists at the Begun Center has a great deal of experience working with mental health, trauma and violence, particularly how these issues affect first responders.

According to the DSM-V a person can be diagnosed with an Acute Stress Disorder if they react to a traumatic event with symptoms in four categories: hyper-arousal, intrusions, avoidance, and psychic numbing. If these physiological, emotional, cognitive and behavioral changes last for more than a month and continue to significantly impair daily functioning, then a person may be formally diagnosed with PTSD.

PTSD as a disorder is characterized by symptoms such as anxiety, depression, dissociation and anger. PTSD can occur from exposure to actual or threatened death, serious injury or sexual violence in one or more of the following:

1. Directly experiencing the traumatic event;
2. Witnessing the event;
3. Learning that a traumatic event happened to a family member or close friend;
4. **Experiencing repeated or extreme exposure to aversive details of traumatic events (e.g. first responders collecting human remains; police officers repeatedly exposed to details of child abuse)**

There are also intrusion symptoms beginning after the traumatic event:

1. Recurrent involuntary distressing memories of the traumatic event;

2. Recurrent distressing dreams;
3. Flashbacks;
4. Psychological distress when exposed to something that reminds us of the traumatic event

Other symptoms can include avoidance, irritability, difficulty sleeping, hypervigilance, and diminished interest in participating in daily activities.

Right after a traumatic event, people experience a range of normal reactions, including: anxiety, feeling “revved up”, fatigue, irritability, hyper-vigilance, increased emotionality, problems sleeping, exaggerated startle response, change in appetite, feeling overwhelmed, impatience, and withdrawing from family and friends. Think of how these reactions would affect the ability of our first responders to do their jobs efficiently and effectively.

Prevalence

Recent prevalence estimates of diagnosed PTSD in the general US population show a rate of about 3% to 4%. Comparatively, PTSD rates for returning Afghanistan war veterans are about three times as high at 11.5%. (In the Cleveland Ohio Division of Police about one third of all police officers have prior military experience, a rate similar to other urban departments).

Police

For police officers there have been many studies of the prevalence of both PTSD symptoms and diagnoses resulting from singular traumatic events or from prolonged exposure. For example, police responders to World Trade Center – 15.4%; first responders to the I 880 freeway collapse – 9% (1989); New Orleans Police officers after Katrina– 19%.

When examining rates of PTSD symptoms generally: New York and Bay Area Police – 34% (1989); Buffalo first responders – 36% reported elevated PTSD symptoms; in New Haven 24% of officers reported PTSD symptoms and Cleveland Heights – 13% (1997).

Firefighters

Several studies of firefighters in the US have shown rates between 17% and 26% (Cornell et al., 1999; Del Ben et al., 2006).

Ambulance/Paramedics

Prevalence rates for PTSD have been reported as greater than 20% in five of seven studies I reviewed.

Two main sources of PTSD

There are two main sources from which a first responder might experience PTSD. The first is during a critical incident or traumatic event experienced during the course of performing their duties. These traumatic events include shootings or killings, crime scenes, car accidents, fires, seeing or recovering dead bodies or sustaining or treating serious injuries.

The second main source of PTSD is the constant stress of daily activities where chronic exposure leads to experiencing the cumulative effects of PTSD. First Responders could be in constant stress about their fear of injury, from long hours on the job; shift work; trying to find an appropriate work-life balance; repetitiveness of the job. For most, every interaction is potentially dangerous, and responders constantly worry about future trauma and violence.

It's important to remember that PTSD rates and negative reactions to stress are not just the result of major traumatic events but can also accumulate throughout a first responder's career. People who have experienced prior trauma are more vulnerable to PTSD than those who have not. This is significant for first responders who are constantly exposed to traumatic events.

Different symptoms are manifested by persons in different ways, sometimes immediately after experiencing a trauma, but sometimes symptoms don't manifest until many years later. Think of a cup full of water representing all of the past experiences of a firefighter or police officer, past military experience or childhood experiences. Every encounter a first responder has adds another drop of water to the cup. We don't know when the cup will overflow or how. It may be a big splash or it could be a small drip but eventually the cup will overflow.

Why should we Care?

First responders have stressful jobs, with PTSD rates that are comparable to returning Afghanistan war veterans, two to over five times higher than in the general population.

Public safety is an issue. Job performance can suffer from changes in the brain from being constantly under stress and being hyper vigilant, with the body always in a state of heightened alertness. Short and long-term physical health is an issue particularly disrupted sleep.

There is a public cost. In one study of police officers in New Haven there was an associated annual cost of \$4,489 in lost productivity per officer with mental health conditions. There are documented increased sick days due to PTSD related health problems.

Employee report increased health issues such as headache, dizziness, pains to the heart or chest, muscle soreness, back pain, obesity, and cardiovascular disease. Many of these health issues lead to early retirement for first responders and shorter life spans. In a UK Sample of 300 mental health was the number one cause of retirement in police. First responders often cite burnout as a reason to retire early. Family and marital instability can contribute to these stressors. Police officers with PTSD are 5 times more likely to be divorced than those without PTSD. Early detection of symptoms and treatment can significantly decrease short-term problems and long term morbidity and mortality. But first responders often wait until it is too late to seek professional help (46.7% of police officers sought help in the New Haven Study).

A real challenge is that first responders do not often take advantage of help through their Employee Assistance Programs for PTSD related problems. Sometimes people are able to recover from acute stress disorder using their own coping skills and support from friends and family. Recovery may be more difficult for some first responders however as they are exposed to major traumatic events and to chronically stressful situations. But there also exists a real stigma around seeking help for emotional problems. Many consider it a sign of weakness and believe if people found out about it others perceptions about their ability to do their jobs well begins to affect their perceived job security. Under these circumstances first responders instead of seeking help may revert to alcohol or drug use or engage in other forms of maladaptive coping that can affect them on the job and influence how they interact with others. Untreated PTSD symptoms also contribute to the significantly high rates of depression and suicide, particularly among police officers.

What does the future hold?

The good news is that we are much more aware of the real problem of PTSD as a serious mental health issue, through our experiences with veterans and from our experiences with first responders to both well publicized tragedies such as 9-11 or Sandy Hook or Katrina but also to the effects of exposure to trauma, violence and human suffering on a daily basis and over time.

The good news is that PTSD can be treated effectively with evidence-based therapies like trauma informed care, cognitive behavior therapy and EMDR- eye movement desensitization response therapy.

The good news is that several other states have passed similar legislation to include coverage for PTSD diagnosed among first responders (e.g. Connecticut, inspired in part by the plight of Newtown police officer Thomas Bean who was nearly fired after using up his accumulated sick and worker's compensation time while battling PTSD after responding to the shootings at Sandy Hook elementary school, South Carolina and New York).

The bad news is that Ohio is not yet part of that group. The bad news is that we have yet to recognize and support with evidence-based effective treatments the emotional injuries that can occur from someone just doing their jobs. First responders every day are faced with circumstances that can result not only in physical injury but, as we are increasingly recognizing, psychological injury as well. We would never think to say to a physically injured officer 'to just get over it.' Yet with PTSD we may indeed be inadvertently giving that message through the ineligibility of PTSD treatment as a legitimate workers compensation claim.

House Bill 308 would seek to remedy this by allowing diagnosed PTSD to be considered comparable to physical injury. I urge you to provide your support for this important provision. Our first responders deserve it, the people whom they serve and protect should demand it. I appreciate your attention to this important matter and would be happy to discuss my position on this with you further at any time.

Sincerely,

A handwritten signature in black ink that reads "Daniel J. Flannery". The signature is written in a cursive, flowing style.

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