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October 22, 2019

Good morning members of the Committee. My name is Nanci Stockwell and I am the Chief Clinical and Education Officer of Advanced Recovery Systems, which oversees the IAFF Center of Excellence in Behavioral Health and Recovery. I am here today in support of House Bill No. 308, at the request of the Ohio Association of Professional Fire Fighters and on behalf of the International Association of Fire Fighters (IAFF). I will discuss the gravity of PTSD in the fire service and how the IAFF has responded by developing the IAFF Center of Excellence for Behavioral Health Treatment and Recovery. I will discuss four key topics:

1. the extraordinary number of potentially traumatic events that fire fighters are routinely exposed to in their work and their increased risk for Post-traumatic Stress Disorder (PTSD)
2. the data demonstrating that PTSD is treatable and need not end a fire fighter's career;
3. the response of the IAFF in developing the IAFF Center of Excellence for Behavioral Health Treatment and Recovery
4. the role of legislation in reducing barriers to treatment access for fire fighters who develop a PTSD as a result of occupational exposure

First, allow me to clarify the role of the IAFF. The IAFF is an international union that represents approximately 313,000 paid professional fire service employees in the United States and Canada. The IAFF has been actively involved in improving the holistic health and safety of fire fighters for more than a century.

Occupational Trauma Exposure in Fire Fighters

First, let us consider some background of the rate of PTSD in the fire service, compared the general civilian population. In the most recent publication of trauma exposure among

American adults, 89.7% of adults had at least one exposure, while the most common number of potentially traumatic exposures in a lifetime was three.

In contrast, firefighters routinely encounter as many as four unique potentially traumatic events in response to a single call. For example, in research conducted with firefighter recruits from seven urban departments, the mean number of exposures to potentially traumatic events during the first three years of service was four events per year (Corneil et al. 1999). Firefighters frequently experience life-threatening accidents, chemical or biological exposure, suicide of co-worker(s) or civilians, multi-casualty accidents, significant life-threatening events involving children, and witness injury or death (IAFF, 1992, 1995, 1999, 2001). Increasingly, firefighters' duties require that they also respond to large-scale catastrophic events, including foreign and domestic terrorist acts, mass shootings, natural disasters, and technological disasters.

One must also consider the cumulative impact of the rate occupational trauma over the course of a fire fighter's career. The overwhelming majority of career firefighters work a minimum of 20 years. Thus, a seasoned firefighter may have a lifetime exposure to well over a hundred potentially traumatic events in a 25-year career, far exceeding the exposure of civilians.

Pioneering work in trauma-related disorders demonstrates that repeated exposures to traumatic events combined with stressful workplace conditions results in meaningfully increased rates of trauma-related disorders, including PTSD. Given the extraordinary trauma load of the fire profession, it follows that firefighter rates of PTSD would be higher than civilian rates of PTSD (about 8%). Considering all available research, consensus among experts is that approximately 22% of firefighters experience full-blown PTSD at some point in their career, and many more suffer subsyndromal symptomatology as a function of their occupational exposure. (For a summary of available epidemiolocal research on PTSD among fire fighters, please contact the IAFF.)

According to a 2018 survey of 6,958 IAFF members, examples of such subsyndromal symptomology are as follows:

- 71% of have trouble sleeping
- 65% report they are constantly haunted by memories of bad calls
- 27% report that work-related stress has led to substance abuse
- 19% report they have had thoughts of suicide

We know that PTSD can have devastating consequences if left untreated and is often associated with other behavioral health disorders, such as clinical depression, substance abuse, family dysfunction, violence and increased risk of suicide. According a 2015 Florida State University study, nearly half of the fire fighters surveyed (46.8%) have thought about suicide, 19.2% had suicide plans and 15.5% had made a suicide attempt (Stanley et al, 2015).

Treatment Outcomes for PTSD

We know that accessible and evidence-based treatment must be part of the solution in responding the PTSD in the fire service. The Department of Veterans Affairs has reviewed the treatment outcome evidence and found that there are multiple effective treatments for PTSD, including Prolonged Exposure (PE), Cognitive Processing Therapy (CPT) and Eye-Movement Desensitization and Reprocessing (EMDR). Approximately 60% of people receiving such evidence-based treatments report symptom improvement, while about 40% no longer meet criteria for PTSD at the end of treatment. These three treatments are structured short-term approaches typically completed in twelve sessions, though individual time frames can vary. This evidence would support that PTSD is a treatable, as opposed to a chronic, condition.

The IAFF Center of Excellence as a Response to PTSD in the Fire Service

In 2015, the IAFF published a featured story in their magazine, *Fire Fighter Quarterly* to increase awareness of PTSD in the fire service. The IAFF reports the response received at IAFF headquarters was overwhelming, with stories from numerous members who called in to share they were struggling with PTSD and felt they nowhere to turn. This was

the genesis for the both IAFF Peer Support Training Program and the IAFF Center of Excellence in Behavioral Health in Treatment and Recovery

To develop the IAFF Center of Excellence, the IAFF entered into a partnership with Advanced Recovery Systems, an integrated behavioral healthcare management company with treatment centers through the United States. Today, the IAFF Center of Excellence is a 64-bed residential treatment center exclusively for IAFF members, who are struggling with post-traumatic stress disorder (PTSD), substance abuse and other behavioral health problems. Since its grand opening in March 2017, the IAFF Center of Excellence has treated 971 IAFF members. Currently, the Center is at full residential capacity, while treating an additional 23 members on an outpatient basis.

The mission of the IAFF Center of Excellence is to address the unique medical, psychological and social needs of fire fighters facing behavioral health crises. Staff is trained to understand the cumulative impact of occupational trauma, as well as the clinical implications of fire service culture and lifestyle. Housed in one of four station houses, patients share an instant bond, forged on a mutual understanding of life in the fire service. While fire fighters function as a highly cohesive social unit on the job, off the job, fire fighters are a clinically diverse patient population that require a variety of treatment approaches to address occupational trauma, co-occurring addiction and other complex behavioral health problems. More than half of patients admitted to the IAFF Center of Excellence screen positively for PTSD based on PCL-5 scale, but other commonly treated conditions include a primary substance use disorder, major depressive disorder, complicated grief, social anxiety disorder, obsessive compulsive personality disorder and other addictions or compulsive behaviors (e.g., sex, gambling, binge eating). The average length of stay at the IAFF Center of Excellence is four weeks, though treatment times vary bases on individual clinical needs, insurance coverage, and other factors. Patients receive telephone outreach and aftercare monitoring for up to 18 months after discharge.

Upon admission and discharge, patients at the IAFF Center of Excellence complete a

series of clinical scales. The data below represent some key findings from a non-scientific survey of 133 patients upon admission, and 91 patients upon discharge:

- Upon admission, 65% of patients meet criteria for PTSD, compared to 7% upon discharge, based on the PCL-5 scale.
- Upon admission, 73% of patients meet criteria for Major Depressive Disorder, compared to 3% upon discharge, based on the PHQ-9 scale.
- The majority of patients admitted meet criteria for hazardous drinking and alcohol dependence, based on the AUDIT scale.

As we have heard from other testimonials today, the cost of not treating PTSD can be high. According to the National Comorbidity Study, individuals with PTSD are six times more likely to attempt suicide (Kessler et al, 1999). The suicide risk among fire fighters may be underscored by the high incidence of clinical depression seen at the IAFF Center of Excellence, as documented by admission scores on the PHQ-9. Additionally, the Department of Veterans Affairs reports men with PTSD are twice as likely to have alcohol problems, while women with PTSD are 2.5 times more likely to have alcohol problems. This is also consistent with high rate of alcohol use disorder detected upon admission at the IAFF Center of Excellence, as noted above.

How Proposed Legislation Can Support Fire Fighters With PTSD

When fire fighters are diagnosed with PTSD as a result of their job, they face a system that is stacked against them. In the absence of the proposed legislation, the fire fighter must prove that his or her PTSD is work-related. This involves finding legal counsel to help with the process and a health care provider who understands the complex causation issues for work-related PTSD, which is much more challenging than for physical injuries. When this PTSD is not covered by workers compensation, fire fighters must use up leave time and may have to use personal savings to cover treatment costs after the insurance maximum is met. These realities create barriers for fire fighters to access treatment for PTSD, which may result in treatment being delayed, deferred, prematurely stopped, or not accessed at all. These barriers should not be placed on fire fighters who develop PTSD, which studies have shown is clearly a result of their occupation and is also treatable.

Several arguments are commonly presented against the proposed legislation. First is the concept of the slippery slope, if we do this for one occupation, we will have to do this for all. As I have shown in my initial discussion on fire fighter exposures, there are dramatic differences between their exposures and the rest of the US workforce. These differences make the proposed legislation uniquely applicable to fire fighters. Secondly, because trauma exposure is common, some have argued that fire fighters had a PTSD diagnosis that preceded their occupation, and so the disability is not connected to their occupation. Fortunately, we have excellent diagnostic measures for determining if the mental health condition is related to fire service and a competent diagnostician can determine if the diagnosis is fire service connected. Finally, and perhaps most compellingly, the cost of educating a new fire fighter far exceeds the cost of treating and returning to duty a fire fighter with a work-related mental health diagnosis.

In summary, multiple epidemiological and clinical assessment studies clearly document that fire fighters are exposed to trauma at high levels in their work. Data also clearly show that fire fighters are at increased risk of developing PTSD. Those who received treatment for PTSD often experience significant symptom reduction and improved daily functioning. We also know that the current workers' compensation system places an enormous burden on individual fire fighters who develop PTSD.

Thank you for your time and consideration.

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