INSTITUTE FOR HOMELAND SECURITY

MENTAL HEALTH PEER SUPPORT IN FIRST RESPONDER ORGANIZATIONS

Institute for Homeland Security
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Executive Summary

In developing a strategy for assisting Texas businesses to identify and respond to potential mental health crises in employees, peer support strategies offer an important, low-cost option. Fellow employees are often better positioned to observe MH symptoms and related behaviors than supervisors or EAP professionals. Peer-to-peer support is often better tolerated and viewed as less intrusive than formal MH intervention. Well trained employee peer mentors can provide basic psychoeducational interventions about a range of issues, be trained to identify indicators of more serious MH problems including the potential for workplace violence, and can refer fellow employees to more comprehensive services when needed.

- Peer-support models have been shown to help reduce PTSD symptoms which can include violence and suicidal ideation. Peer support strategies developed with this complex population can help inform a wide range of work-place based peer mentor programs.

Background

Because of work related trauma exposure, first responders are at increased risk for Post Traumatic Stress Disorder. Further, where civilians may be exposed to a handful of potentially traumatizing events over their lives, first responders are repeatedly and cumulatively exposed [1] to accident scenes, shootings, and other events where lives have been lost or serious injuries have occurred [2]. The culture of first responder units often makes seeking formal mental health services less attractive, as seeing a licensed therapist can be viewed as an admission of weakness [3]. In some cases, seeking professional care and the assignment of a PTSD diagnosis may have implications around being seen as fit for duty or later employability [4].

Nationally, the prevalence rate for PTSD in police is 14.2%, 7.3% for firefighters and 14.6% for emergency medical technicians [5-8]. While all of these responders have considerable exposure to traumatic events, screening procedures for police and fire select for individuals who are particularly resilient, and many may have sub-threshold symptoms [8, 9]. Individuals in non-sworn roles, e.g. dispatchers are also at considerable risk from secondary exposure to trauma (e.g. 911 calls, coordinating services for large scale fatal accidents, etc.) [9].

Each state has its own specific considerations, and similar demographic and prevalence rate information should be gathered for Texas. For our team in Wisconsin, the following information has been instructive:

> Wisconsin has approximately 12,000 sworn police officers, 34,000 firefighters, and 54,000 EMTs [10]. Additionally, potentially trauma exposed dispatch and support staff for these services likely number in thousands. Comparing WI populations figures for these

groups to national prevalence data for PTSD within these groups, some 12,070 WI first responders are likely to suffer from work related trauma exposure. Based on national prevalence estimates, as many as 24,000 WI emergency responders engage in problem/binge drinking each year, and as many as 10,000 misuse prescription opioids.

Our own ethnographic work with this population has emphasized that while first responders are often viewed as a monolith, each group, police, fire, EMT/paramedics have unique working conditions, team composition, expectations, and cultures. For example, while first responders may debrief a major accident as a team and be able to provide informal peer support for individuals struggling with the aftermath of the accident, police and sheriffs' deputies often work alone or two person units. Focus groups conducted by my research team (Franco, unpublished) suggest that police and sheriff's deputies often come to see themselves capable of dealing with anything on their own because the role, and the daily work alone in a police vehicle, forces them to be self-sufficient. This can result in increasing isolation and inability to ask for mental health support when it is needed. Further, because of the isolating working conditions, few people may be in a position to observe a first responder who is experiencing significant distress and entering into mental health crisis. Shift work, changing schedules, and lack of sleep were also noted as risk factors.

Opioid misuse in first responders is increasingly common and is often underrecognized by police chiefs and other executives in first responder organizations [11], and alcohol misuse is a historical problem for this population, although detailed research on the prevalence of these problems in the first responder community remains striking [12, 13]. Models of drug and alcohol use in first responders suggest that occupational stress, length of service, high call volumes, lack of exercise, and physical injuries or related somatic problems are the major drivers for substance misuse in this group [13].

In part because of the concerns around stigma and operational readiness in this population, informal peer-to-peer mental health support may be a particularly effective intervention. Peer mental health strategies are low cost, typically working with individuals from a particular community who have an interest and existing aptitude in reaching out to others. Mental health peer support training can be integrated into the broader training cycles for first responders. A number of approaches for first responder peer support exist [14, 15], ranging from historical approaches like CISM [16] to modern versions involving technology to help facilitate communication among first responder peers who may not work directly together [17]. CISM strategies have mixed results, particularly when applied to civilian incidents, and the research around these issues suggests that team composition and cohesion are particular important considerations in the development of peer-to-peer support. The workplace context – e.g. team based peer support for firefighters, versus thoughtful pairing of individual police offers is an area that requires additional formal study.

Problem

While some first responder organizations have established mental health peer mentor programs, standardization around training domains remains largely absent. Further, for smaller police and fire departments, designing, deploying, and managing peer mentor programs in house represents a substantial administrative and fiscal burden.

Moreover, issues around adoption of the approach may also exist at the rank-and-file level. For example, training materials that are viewed as borrowed from the civilian world, and not tailored to the issues, experiences, and values of the first responder community may struggle to be adopted. These issues suggest that developing peer mentor programs that are built carefully "from the ground-up" using ethnographic approaches to design training materials specifically tailored to the issues and considerations for this population are key.

Current State of the Art

In our work in Wisconsin, we have developed a peer mentor training program for US military veterans focused on the basics of the peer mentor process and addressing topics like PTSD, anger management, opioid misuse, and service-related suicide. These training manuals were developed by combining academic experts in these fields with US military veterans under the guidance of an anthropologist or ethnographer. The ethnographic specialist then worked with a graphic designer and artists from within the veteran community to tailor the manual so that it would be visually appealing and speak to the culture of the veterans.

"Porting" peer mentor training programs from domains and groups that are most similar to first responders, and then adjusting content and graphic designs for this population is an approach that we are taking here in Wisconsin to bootstrap this process – particularly for smaller, rural departments. One key remaining problem with training US military veterans in mental health peer support is developing scalable training. Currently, our trainings run about 40 hours and require at least one peer mentor trainer to be present during the week-long training. A co-facilitator is beneficial, making this a fairly resource intensive process. We have been examining online training platforms for peer support as a way to increase the number of peer mentors who can be training. This approach can also facilitate access to training for emergency responders interest in the role from rural departments.

We have also developed a mental health peer support smartphone app that can be used with multiple populations. Originally developed for the veteran population the BattlePeer app is currently being revised for and tested with first responders (www.battlepeer.com).

Future Solutions

Future solutions for peer support in first responder communities might involve deeper tailoring for each service – police, fire, EMT, dispatch, etc., customized to the unique needs, work related exposures, and working environments for these groups. Yet, at the same time, our focus group

work suggests that creating inter-agency connections among first responder peer mentors may provide an important way to reduce isolation and foster social support. There may be situations where a first responder also prefers to work with a peer support specialist from a different agency because of concerns around privacy vis-a-bis their chain of command. Perspectives offered from peer support specialists across several services may also enrich the conversation as different types of coping strategies, stories about past incidents, and personal styles may be key to outreach with a first responder who is really struggling.

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