CRITICAL INCIDENT STRESS MANAGEMENT PROGRAMS IN WASHINGTON STATE

ASSESSMENT

2021

CRIMINAL JUSTICE TRAINING COMMISSION
WASHINGTON

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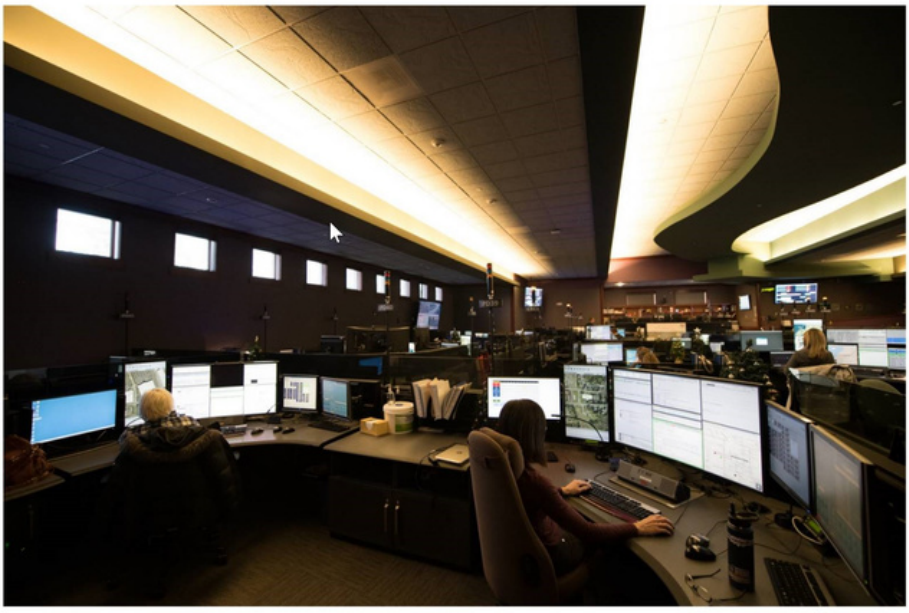
EXECUTIVE SUMMARY

The Washington State Legislature signed House Bill (HB) 2926 into law in April 2020. The intent of this bi-partisan bill is to review and expand access to critical incident stress management programs and added 43.101.800 to the Revised Code of Washington.

The Washington State Criminal Justice Training Commission (WSCJTC) contacted the Critical Incident Stress Management (CISM) Network from around the state to determine if and how CISM was utilized in response to critical incident situations. WSCJTC then dispatched a survey to first responder communities in Washington to obtain a comprehensive view of how first responders are being supported in wellness programs beyond CISM. This survey was sent to the fire industry, city police, county sheriffs, Washington State Patrol, University Police, Tribal law enforcement, local and state dispatchers, local and state corrections, state probation, and local and state juvenile corrections.

This report analyzes the results of those inquiries.



Telecommunications Staff at Valley Communications Dispatch Center in Kent, WA.

ACRONYMS

AAR – After Action Review
CID – Critical Incident Debrief
CISM – Critical Incident Stress Management
DOC – Department of Corrections
EAP – Employee Assistance Program
HR – Human Resources
ICISF – International Critical Incident Stress Foundation
MHP – Mental Health Professional/Mental Health Clinician
WSCJTC – Washington State Criminal Justice Training Commission

INTRODUCTION

Imagine our first responders being in a peak state of being prior to every call to action; balanced physically, emotionally, and mentally. How would this shape their decisions? How would this impact the outcome? What image of our responders would the community hold?

The outcomes we seek in a democracy rely on human performance. A human's ability to perform is always predicated on their state of being; not just training and not just mindset. Professionals immersed in an impoverished environment, experiencing extreme hypervigilance and subjected to daily trauma, while missing sleep, nutrition and exercise will likely not be able to access the performance we expect.

Our solution must be focused on the 'state of being' of first responders. Understanding the state of being allows us to access our knowledge, skills and training to affect an outcome. The first responder community has not been provided the framework for 'state' management. There is an opportunity to give our responders that framework to govern their lives and have them functioning in a state of peak performance. To provide more skills without providing the capacity to access those skills is wasteful.

THE PROCESS

In developing the comprehensive survey, WSCJTC placed focus on current agency response to critical incidents/ significant events as well as the proactive measures that are provided for the overall health and wellness of first responders.

The survey (found here) was disseminated among 500+ contacts from the following agencies across the state of Washington: fire industry, city police, county sheriffs, Washington State Patrol, University Police, tribal law enforcement, local and state dispatchers, local and state corrections, state probation, and local and state juvenile corrections staff and facilities. We received a total of 258 survey responses from these respective agencies.

Following is how the survey questions were developed:
First, we needed to determine who was utilizing the Critical Incident Stress Management (CISM) specifically from the International Critical Incident Stress Foundation, Inc. (ICISF) as well as other programs that are utilized in lieu of CISM in response to critical incidents.

Critical Incident Stress Management (CISM) is a peer-driven method of crisis intervention designed to provide support for first responders and others who have been involved in traumatic critical incidents that affect them emotionally and/or physically. CISM is a process that enables peers to help one another understand problems that might occur after a critical incident. Critical incident stress debriefings were officially introduced in the 1980s. In the early 1990s, the International Critical Incident Stress Foundation was developed, and by 1997, CISM was incorporated as a comprehensive system of crisis intervention techniques with a focus on first responder care.

In order to find out how these options are mobilized, we asked how a critical incident is defined or determined and by whom. We also asked how agencies measure the effectiveness of the programs that are used and what barriers prevent staff from accessing them. Lastly, we wanted to know if those who provide support or response to a critical incident were trained in trauma informed care. We also needed to determine what proactive measures were in place for officer wellness. Agencies were asked to provide what is offered for stress management (i.e., fitness incentives, nutrition programs, sleep programs or any other training). We inquired as to how agencies measured the effectiveness of these programs and what barriers prevent people from accessing wellness resources. These are the efforts being made to contribute to the overall wellness of officers independent of a critical incident.

For the purpose of this report, we will expand the scope of interest beyond "critical incidents" to the broader "significant events" to encompass the exposure first responders have to stress events that effect well-being. By broadening the scope of interest, we can create a framework for response to on-the-job experiences. Below are terms that will be used throughout the report.

Trauma: An individual's perception of an event as threatening to oneself or others. (Trauma Resource Institute)

Secondary Trauma: Psychological effects acquired through exposure to person suffering the effects of trauma. (Baird and Kracen -2006)

Vicarious Traumatization: harmful changes that occur in the professionals' views of themselves, others, and the world as a result of exposure to the graphic and/or traumatic material of others. (Baird and Kracen -2006)

Critical Incident: An event out of the range of normal experience – one which is sudden and unexpected, involves the perception of a threat to life and can include elements of physical and emotional loss. Often such events are sufficiently disturbing to overwhelm, or threaten to overwhelm, a person's coping capacity. Most people would be severely shaken by a critical incident but are likely to recover from its impact with appropriate support. (World Health Organization)

Post-traumatic stress disorder (PTSD): A disorder that develops in some people who have experienced a shocking, scary, or dangerous event. (National Institute of Mental Health)

Complex PTSD – National Center for PTSD

Many traumatic events (e.g., car accidents, natural disasters, etc.) are of time-limited duration. However, in some cases people experience chronic trauma that continues or repeats for months or years at a time. Studies suggest that the current PTSD diagnosis does not fully capture the severe psychological harm that occurs with prolonged, repeated trauma.

Additional information regarding Complex PTSD as it relates to the behavior we see prevalent in the first responder community:

In 1988, Dr. Judith Herman of Harvard University suggested that a new diagnosis, complex PTSD, was needed to describe the symptoms of long-term trauma. Such symptoms include, according to her formulation:

- Behavioral difficulties (e.g. impulsivity, aggressiveness, sexual acting out, alcohol/drug misuse and self-destructive behavior)
- Emotional difficulties (e.g. affect lability, rage, depression and panic)
- Cognitive difficulties (e.g. dissociation and pathological changes in personal identity)
- Interpersonal difficulties (e.g. chaotic personal relationships)
- Somatization (resulting in many visits to medical practitioners)

"There are approximately 900,000 sworn officers in the United States. According to some studies – 19% of them may have PTSD. Other studies suggest that approximately 34% suffer symptoms associated with PTSD but do not meet the standards for the full diagnosis" (Ellen Kirschman Ph.D. - Psychology Today 2017).

With an understanding of the terms, it is easy to see that first responders are exposed to trauma on a regular basis which presents an incredible paradox: an expectation of optimal performance with constant subjection to stimuli which inhibits optimal performance.

In addition, determining what programs are offered by agencies, we need to ask whether those resources are being used and further whether they are working.

Officer suicides far exceeds line of duty deaths and in 2019 while line of duty deaths were decreasing, the suicide rate was increasing, making officers the greatest threat to themselves. It is clear there is a certain amount of turmoil that accompanies these positions that would require ongoing maintenance for wellness.

THE FINDINGS

First, we looked at proactive resources. These were the measures being taken to promote wellness regardless of exposure to a significant event. These were covered in questions 2-7.

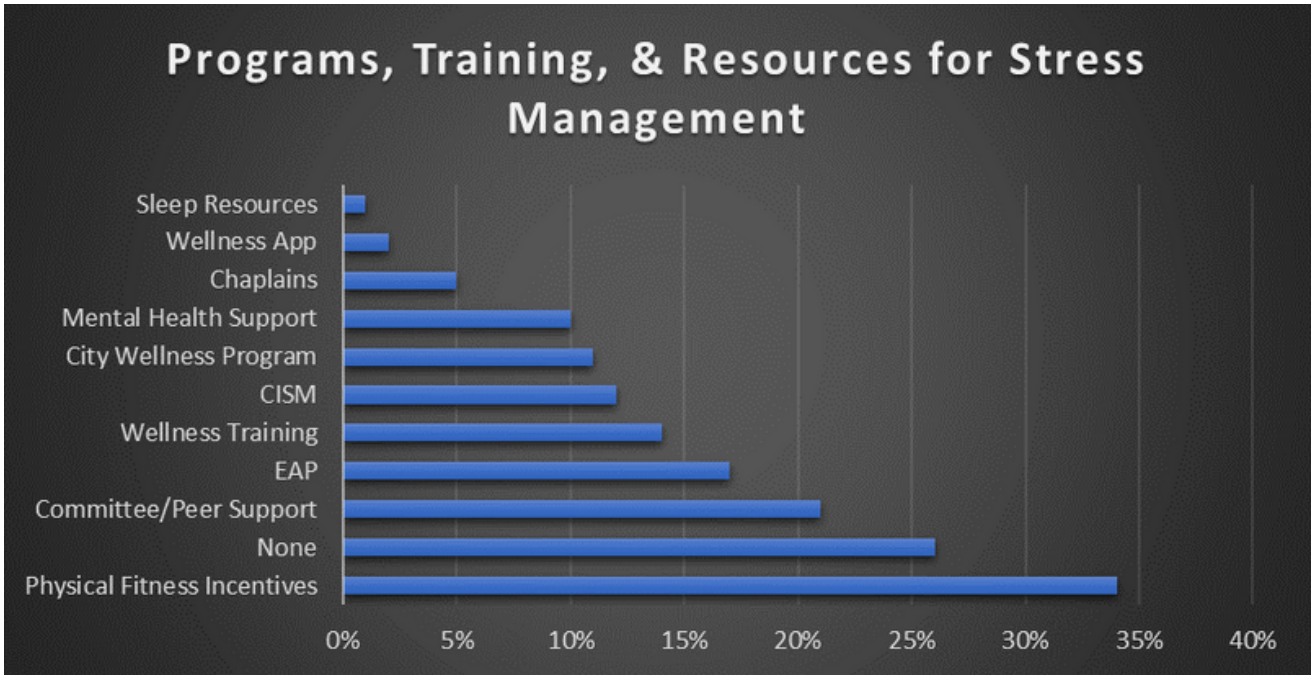
- What stress management resources are available
- Are those resources that are available measured for effectiveness
- Are staff willing to use the provided resources
- How many are accessing the provided resources

Second, we looked at the reactive resources offered following a critical incident. These were the resources allocated in response to significant events. These were covered in questions 8-13.

- What programs, training, or resources are offered in response to a critical incident
- How the effectiveness of these programs is measured (do they work)
- How willing staff are to participate
- What barriers there are to accessing available resources
- How a critical incident is determined/defined
- Are agencies using CISM specific resources
- Are those providing assistance educated in trauma informed response

NOTE: The percentages listed below are inclusive of all agency resources offered. Therefore, the percentages show overall access across industries. For instance, 25% of any category simply means 25% of the respondents indicated that category as a response.

What programs, training, or resources does your agency have for stress management (ie: fitness incentives, sleep & nutrition programs) ? Name/ describe these. [Q2]



Physical Fitness – 34%

The biggest effort being made in this area across all industries was in the realm of physical fitness. This category encompassed time to exercise on shift, exercise equipment provided, reimbursed gym dues, fitness challenges, fitness incentives, and information and resources on other smaller programs.

Peer Support/Committee – 21%

The second biggest effort is being made through specialized social networks such as peer support, wellness committees, personal assistance teams, and mentorship programs.

Employee Assistance Program – 17%

Although we know agencies have access to EAP, just under 17% or respondents reported EAP as a resource for stress management.

Wellness Training – 15%

This encompasses any training around emotional resilience, sleep, and mental health.

CISM – 12%

CISM was provided as an answer for just under 11% of the responding agencies.

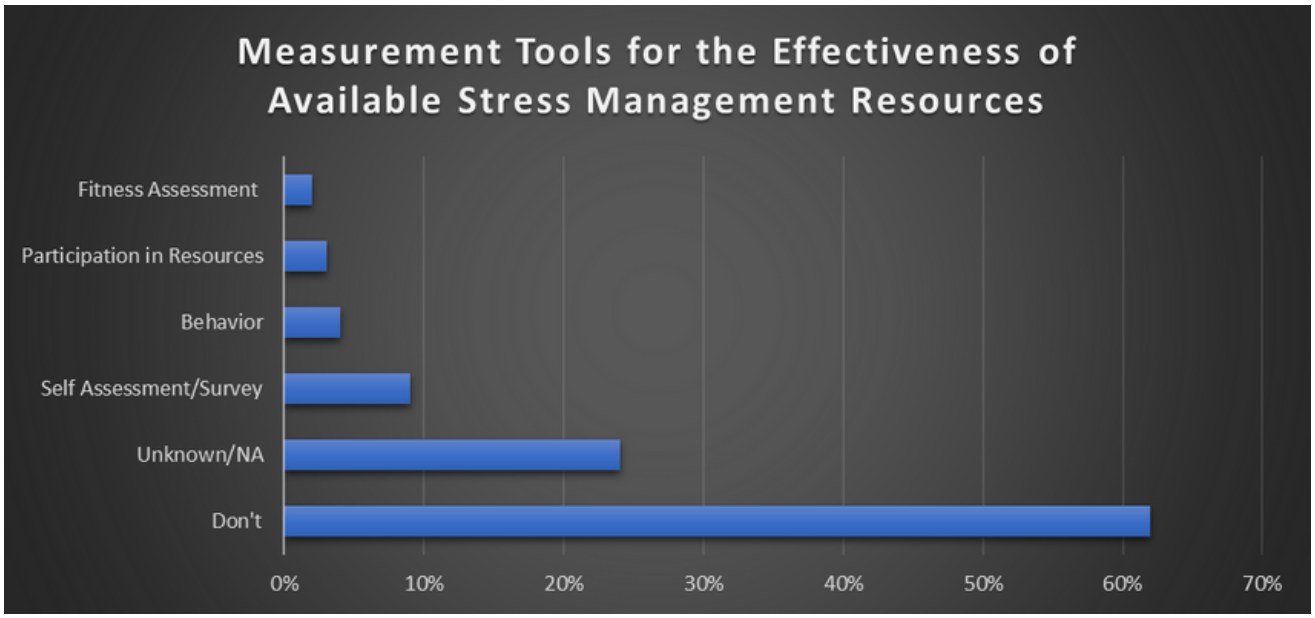
MHP – 10%

10% of agencies have taken steps to ensure their employees have access to mental health clinicians on a regular basis.

None – 26%

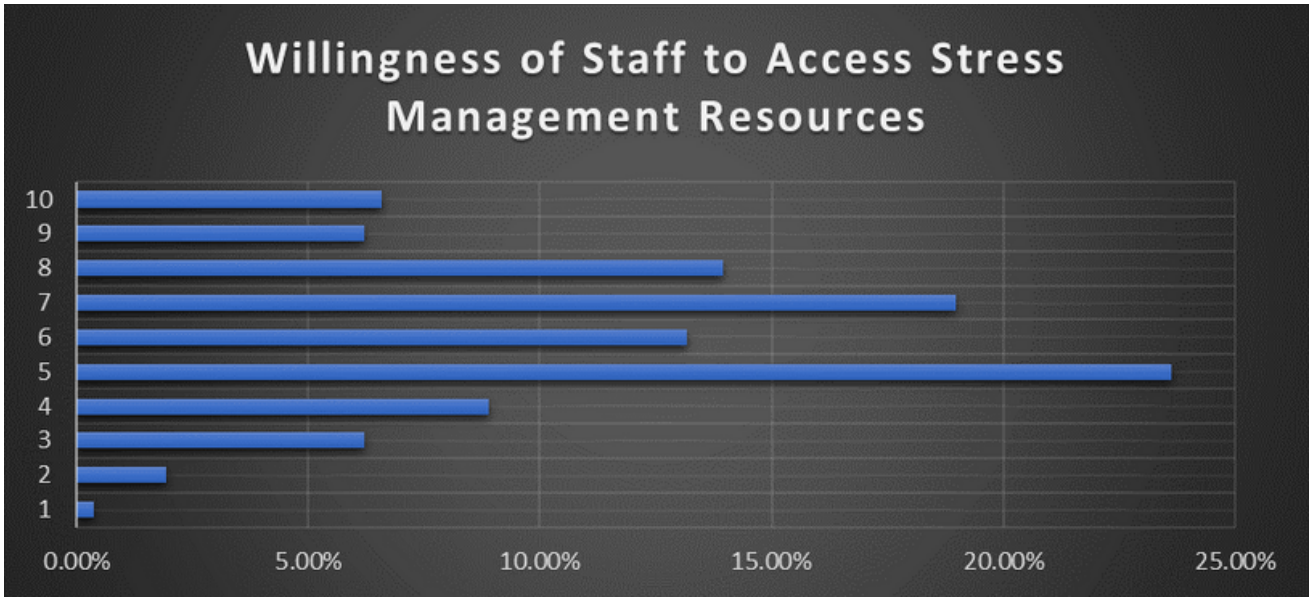
26% of agencies said there are no resources for stress management. This makes this answer tied with for the second most provided answer to this question.

How does your agency measure the effectiveness of these stress management programs? (name specific programs/ measurement tools) [Q3]



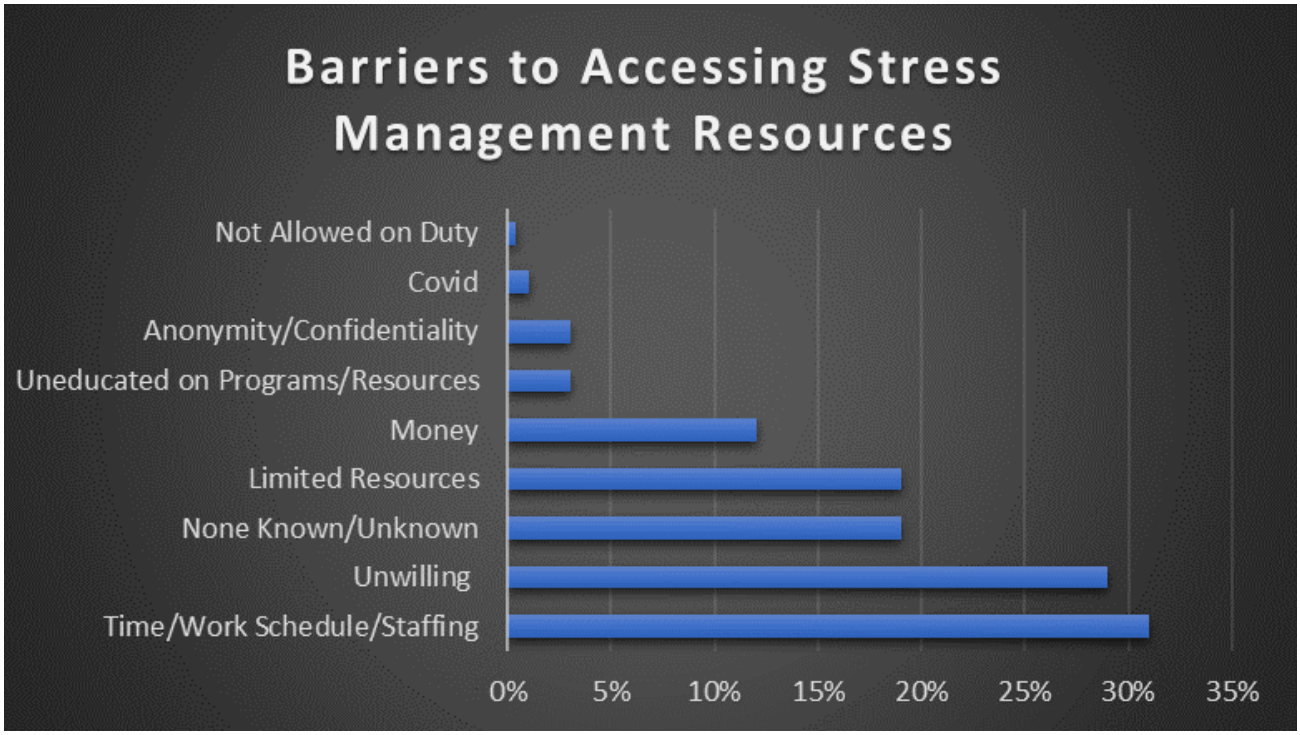
This question provides understanding for whether the resources provided are helping. Unfortunately, the largest response to this category (62%) was there were no measures in place. The second biggest response (at 24%) was that it was unknown whether there was a measurement or not. This left only 14% of respondents with some form of measurement. Those measurements included: annual fitness tests, behavioral changes in employees, self-assessments, and participation rates.

On a scale of 1-10 (1 being completely resistant and 10 being completely willing) how willing are those in your agency to participate in these stress management programs? [Q4]



The data shows that most agencies would be moderately willing to participate in stress management programs, with 23.64% answering 5/10 on the scale. Only 6.6% responded as completely willing and less than 1% said they were completely unwilling.

What barriers are there to accessing these stress management resources? [Q5]



Time/Staffing/Scheduling – 31%

First responders are faced with time constraints: long hours, extra shifts and minimal staffing. This creates a paradox.

Officers do not have the opportunity to use the resources that would assist them in maintaining a mental and physical healthy disposition.

Employee Unwillingness – 29%

This category considered all the resistance responses we received. Among the top responses were the stigma of appearing weak and distrust of third-party resources.

Unknown – 19%

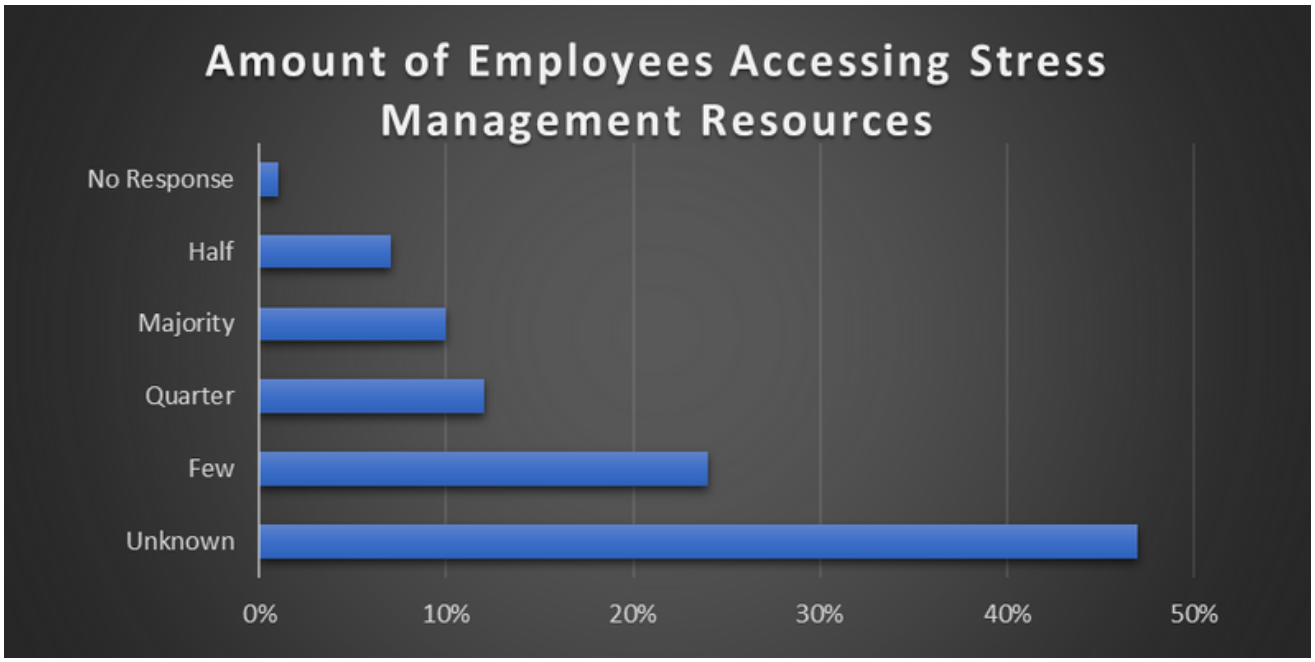
Limited Resources – 19%

19% indicated not having access to the resources needed. In many cases the stress management resources were available but employees were not provided the time to access them. This illustrated the need for time to access the resources and creating the education and buy-in for participation in those resources.

Funding – 12%

Funding was the final major barrier to accessing stress management resources.

How many officers / support staff currently utilize these stress management programs? [Q7]



This question was to determine how many responders are accessing the resources provided by their agency. It is evident from this response that the majority of first responders are not accessing stress management resources that are provided by their agencies. 24% reported that very few participate in accessible resources and 12% reported that only a quarter participate. 7% reported that half of their peers participated and 10% of respondents said the majority of the officers in their respective agencies participated in stress management resources.

What programs, training, or resources does your agency have for officers/ support staff after critical incident response/s? Name / describe these. [Q8]

Committee/Peer Support – 37%

This shows how much peer-to-peer support is utilized, being the biggest overall category of this section. This gives insight into what programs officers are most comfortable accessing. Unfortunately, these programs are often run voluntarily and get minimal training or resources.

CISM – 30%

Just over a quarter of the respondents stated they utilize CISM in response to critical incidents. Some claimed to use CISM but do not follow the protocols of CISM and have adapted it to a more usable format.

Debriefs – 21%

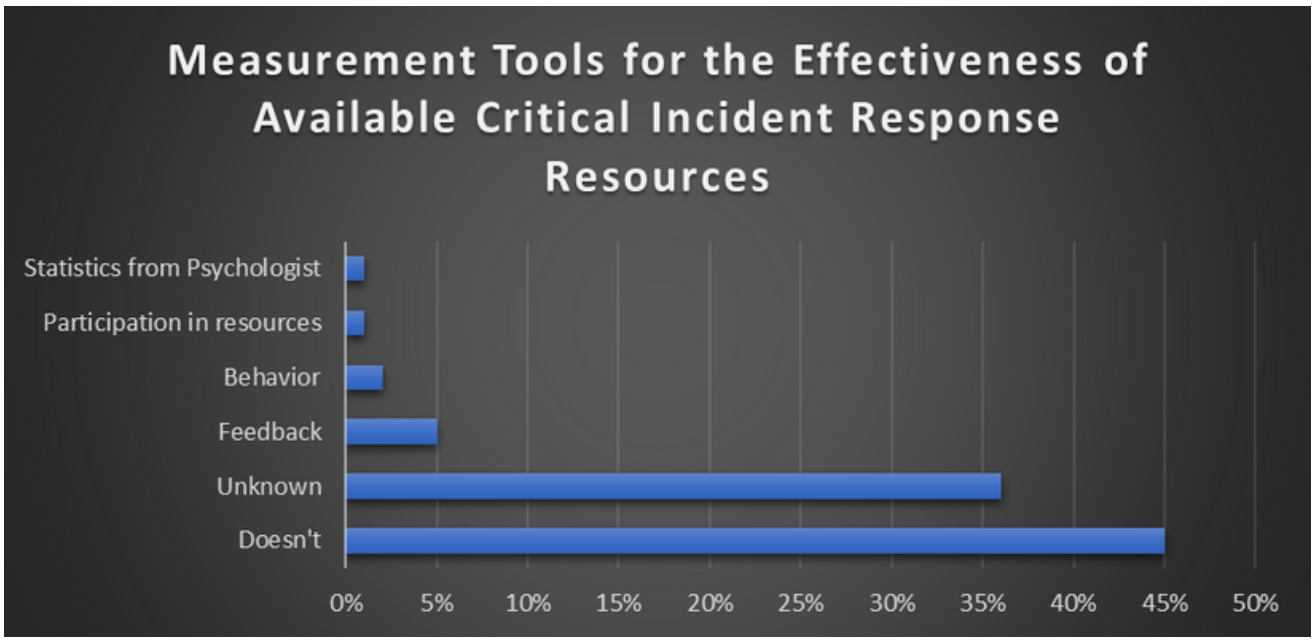
Another quarter of the agencies reported to be doing some debriefs if not CISM. The debriefs ranged from informal gatherings following significant events to a very formalized process independent of the CISM format.

Chaplains – 15%

Agencies utilizing chaplains appeared to give them resources for responding to significant events including training on critical incident debriefs and CISM.

None – 11%

How does your agency measure the effectiveness of these critical incident response programs? (name specific programs/ measurement tools) [Q9]



Not measured – 45%

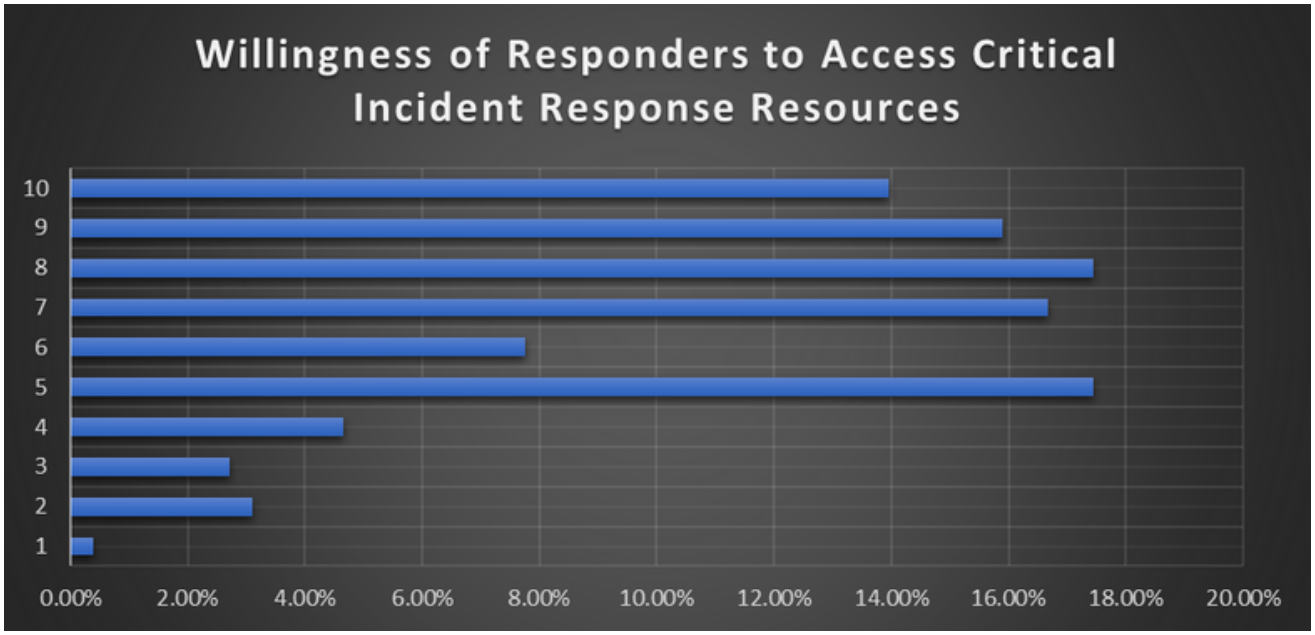
Unknown – 36%

Nearly half of the agencies said they do not measure the resources used for critical incident response to determine efficacy, and another third said they do not know. Although first responders may be accessing resources, it is undetermined whether those resources are working. Without ascertaining whether the resources are helping maintain the wellness of employees, those resources can be seen as merely a box to check.

Behavior/Feedback from those involved – 5%

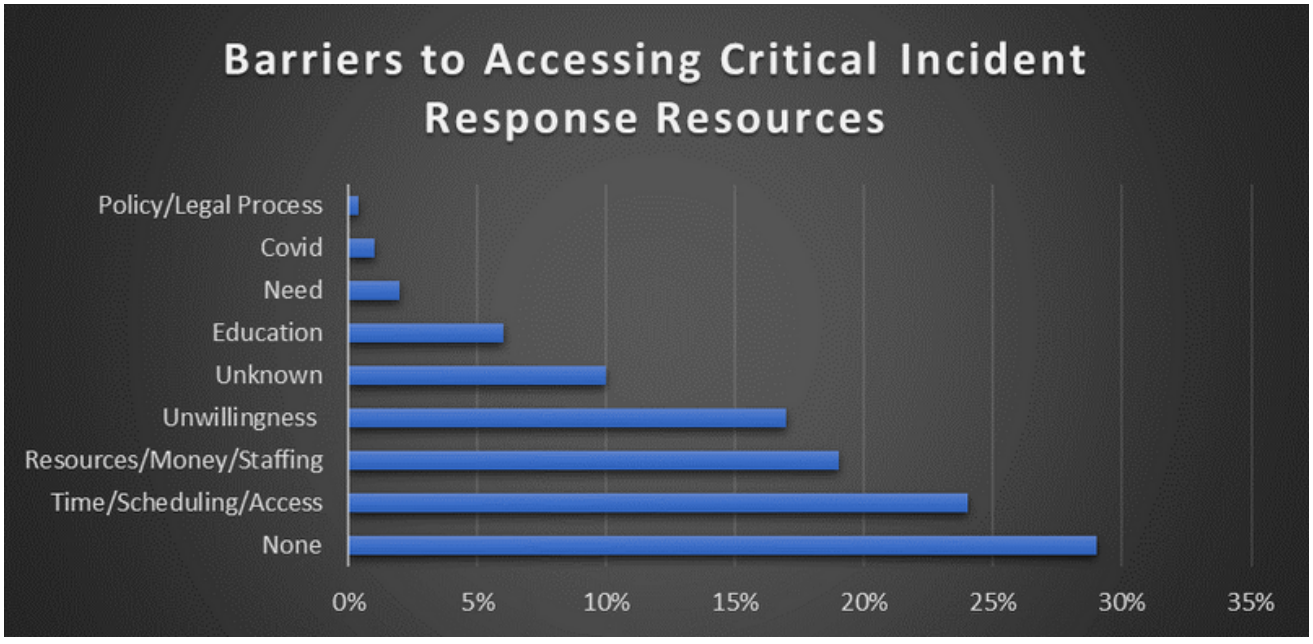
Although only 5% of those surveyed gave this as a measure, it was the highest of any measure. This relies on the employee to understand their reaction to the experience, and to give an honest assessment to those inquiring.

On a scale of 1-10 (1 being completely resistant and 10 being completely willing) how willing are those in your agency to participate in these critical incident response programs? [Q10]



Employees are willing to participate in critical incident response resources. It is evident through this data that employees are mostly willing to participate in critical incident response programs. In totality, 89.14% of agencies said they were moderately (5/10) to completely willing (10/10) to participate in critical incident response resources.

What barriers are there to accessing these critical incident response resources? [Q11]



None – 27%

Time/Scheduling/Access – 23%

In contrast to this category for stress management resource barriers, this is directly in response to a critical incident a responder was involved in. Meaning, scheduling time or prioritizing staffing is not given precedence roughly a quarter of the time, making it the biggest overall barrier to overcome.

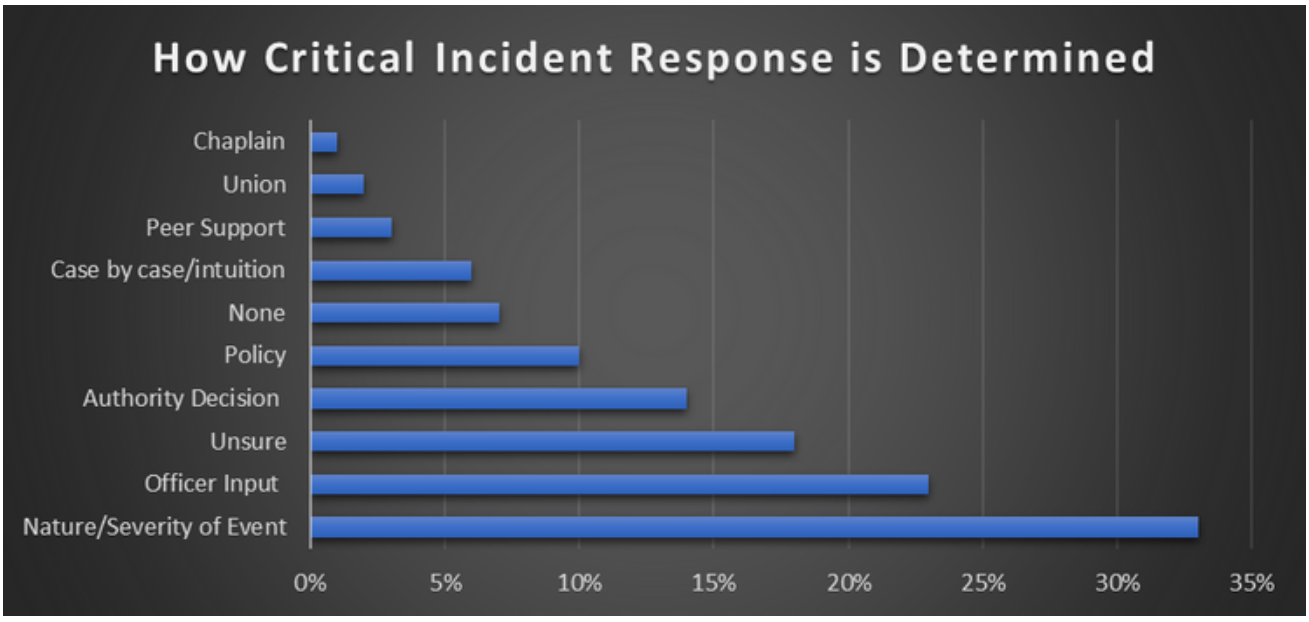
Resources – 19%

19% of respondents claimed to not have the resources to offer in response to a critical incident. If all of the other barriers were removed, roughly 1/5 of responders would not have access to the resources to effectively process the experience of a critical incident.

Unwillingness – 18%

Responder unwillingness encompassed a few barriers, such as: the stigma of appearing as if they cannot handle the stress of the event, a lack of trust for third party response, and resistance to vulnerability. This may also indicate that there is a lack of understanding or buy in that prevents responder participation.

How do your agency determine what events warrant critical incident response? [Q13]



We know that most agencies have some response to a critical incident, but many do not have a criterion for what constitutes a critical incident. Consequently, there may be resources available that are not accessed due to how an incident is categorized.

Severity of the event – 34%

This was the largest factor for determining a response or action following a critical incident. There were a wide array of answers including: officer involved shootings, scenes involving death or dismemberment/grave bodily injury, prolonged stress incident, crimes against children or animals, and other low frequency/high impact calls.

Officer Input – 21%

This second largest category encompassed, not just self-reporting or responder request, but also how employees responded to the event. This included behavioral changes, mental and emotional responses, and overall impact to those involved. The lapse in this method is relying on those who experienced the event to access resources. As stated in the previous question, the unwillingness created by stigma and distrust created a barrier to honest feedback.

Unknown – 18%

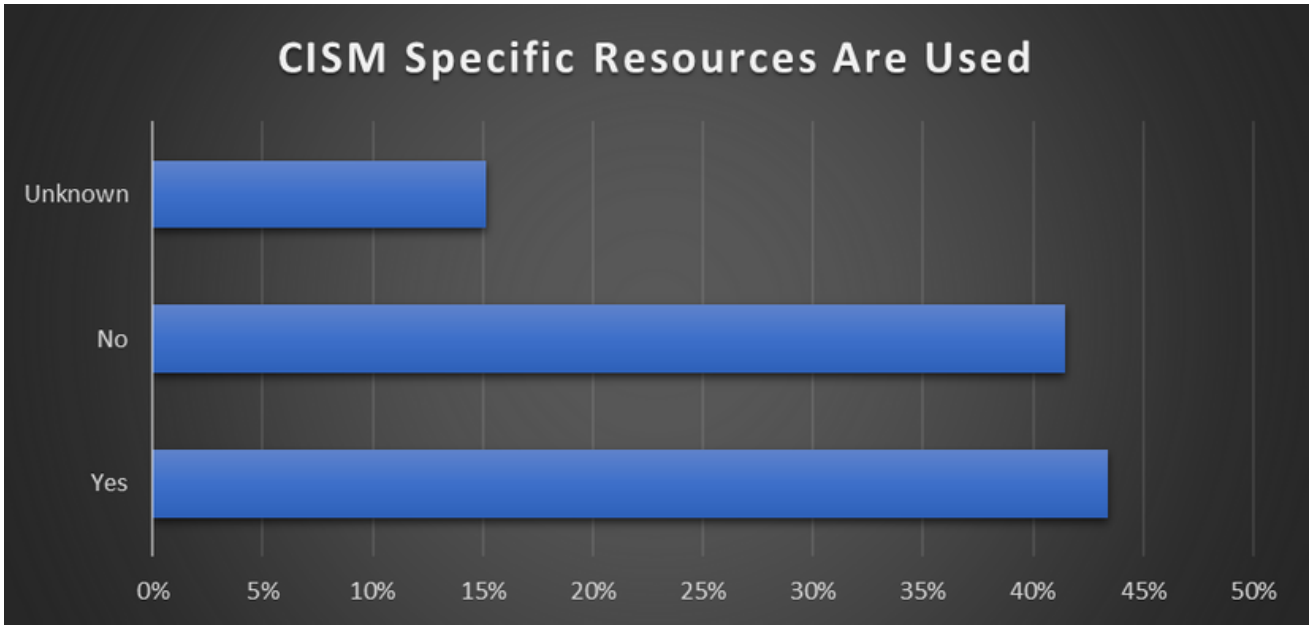
Authority Decision – 15%

This was both direct/first-line supervisor as well as command staff decisions combined.

Policy – 10%

Only 10% of respondents indicated they had a policy regarding critical incident response. This may mean that only 10% of respondents were aware of the policy. Regardless, based on the responses, only 10% were using policy as a means of determination.

Does your agency utilize CISM-specific resources? [Q14]



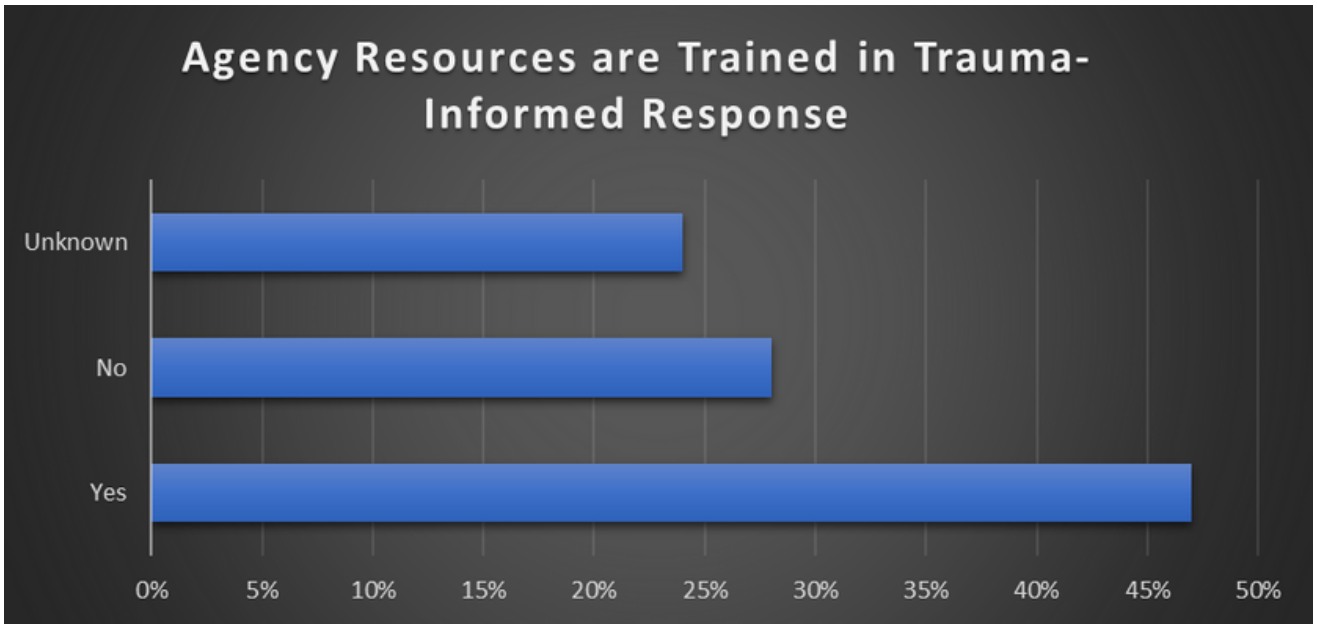
Yes – 44%

No – 42%

Unknown – 14%

This indicates roughly half of the first responder agencies are utilizing CISM.

Are your agency / peer support teams educated / trained in trauma-informed response? Describe. [Q15]

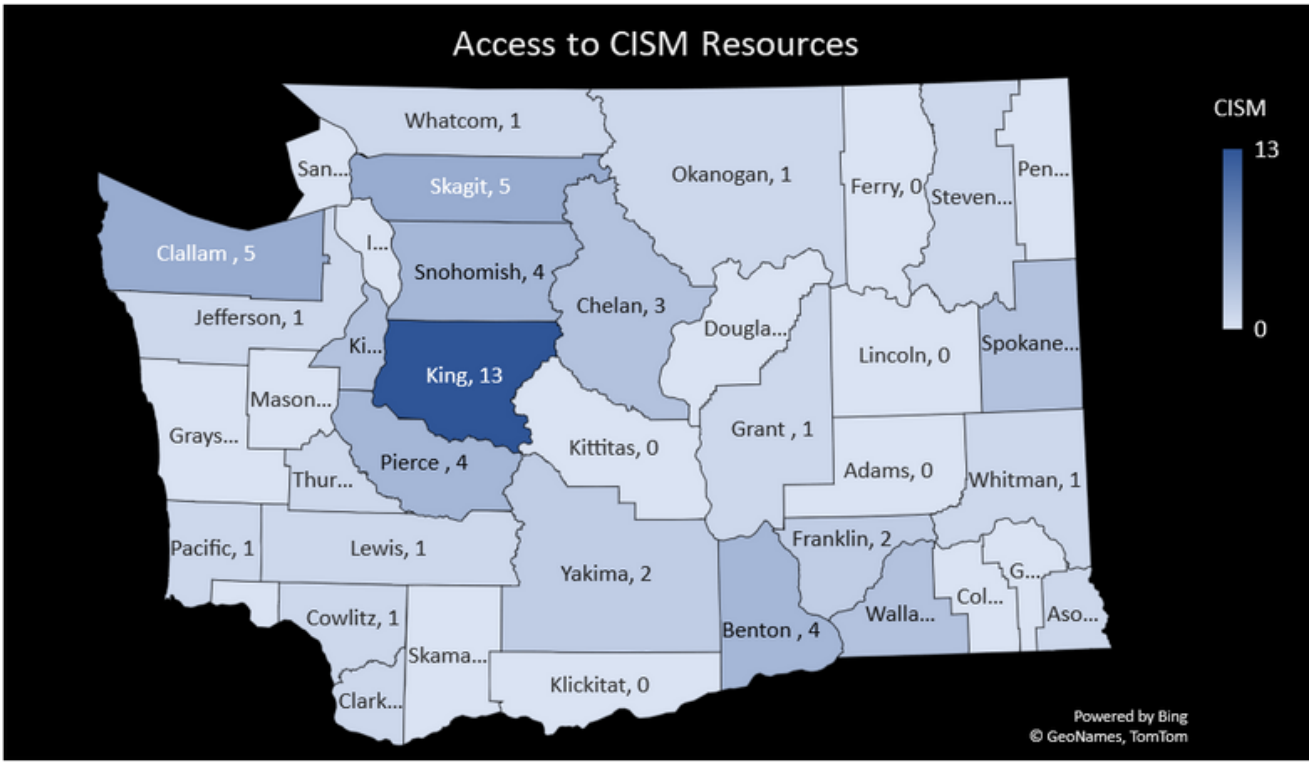


Yes – 47%
No – 28%
Unknown – 24%

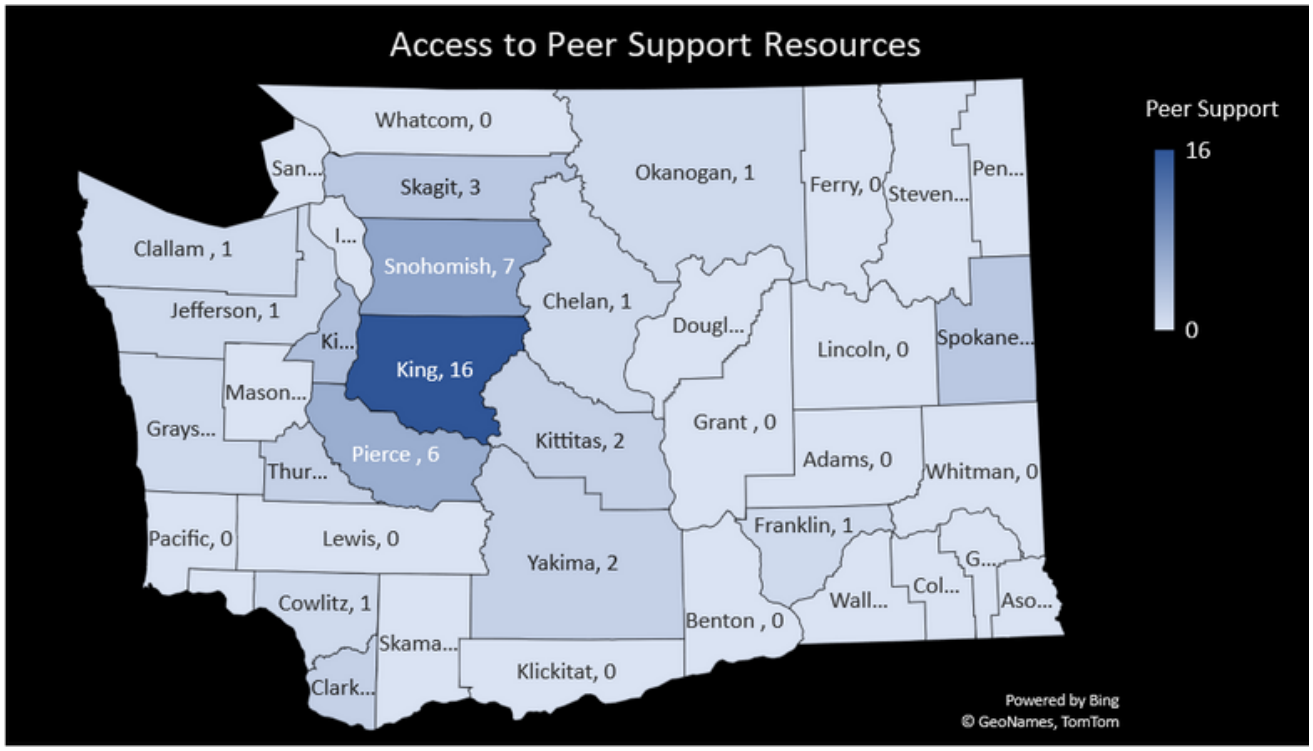
County Breakdown by Resources

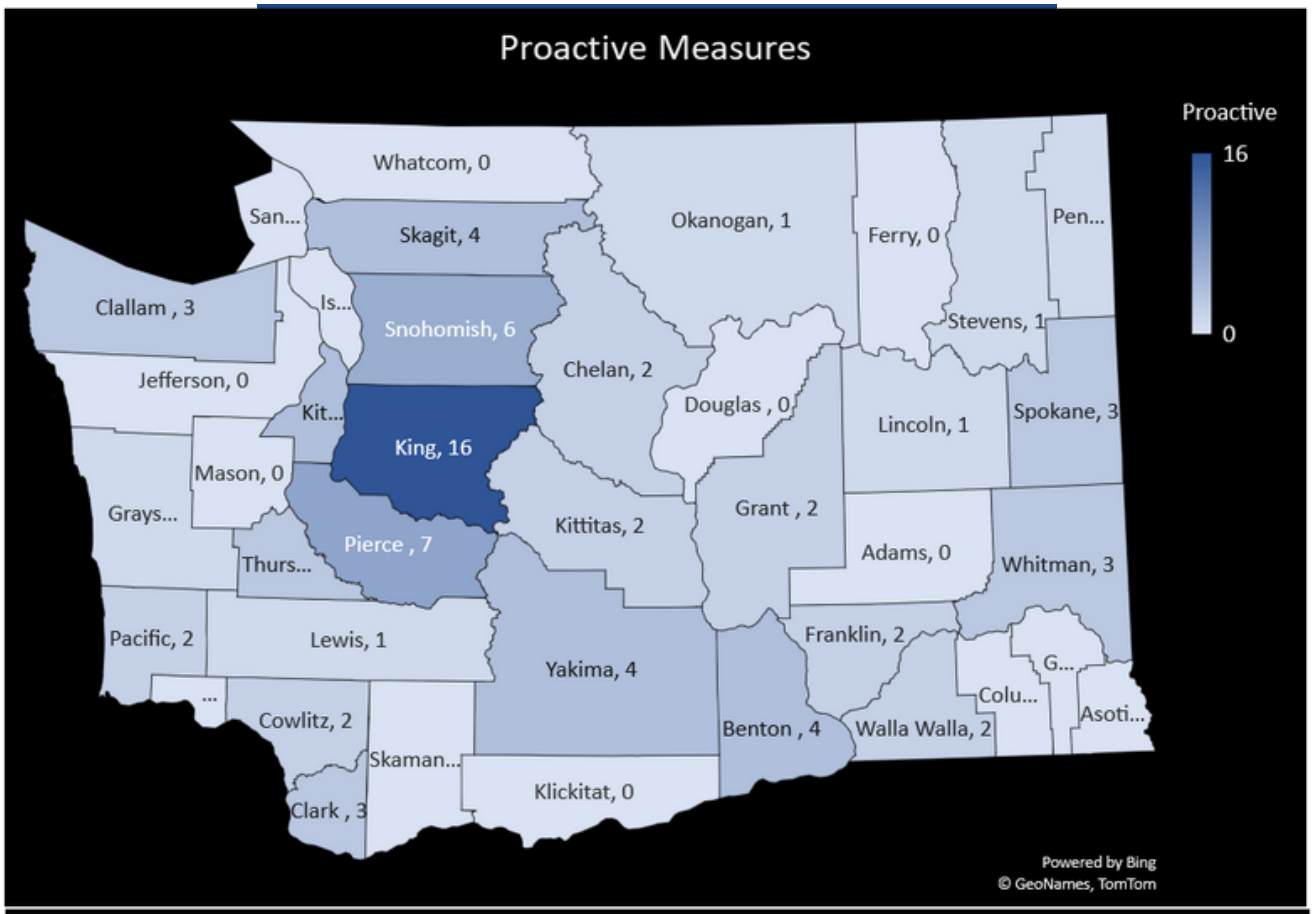
The below charts are based on the survey responses received. The individual city police departments, fire districts, detention facilities and communications centers were added into their counties to calculate total in their area. The first chart identified areas with CISM as a resource to responding agencies. The second identified areas where peer support programs were utilized. The third chart illustrates areas that have proactive programs for health and wellness of staff. The last depicts areas with resources of programs for responding to a critical incident. These numbers are based on the agencies who responded to the inquiry.

CISM-Specific Resources by County



Peer Support Resources by County

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Stevens, 1
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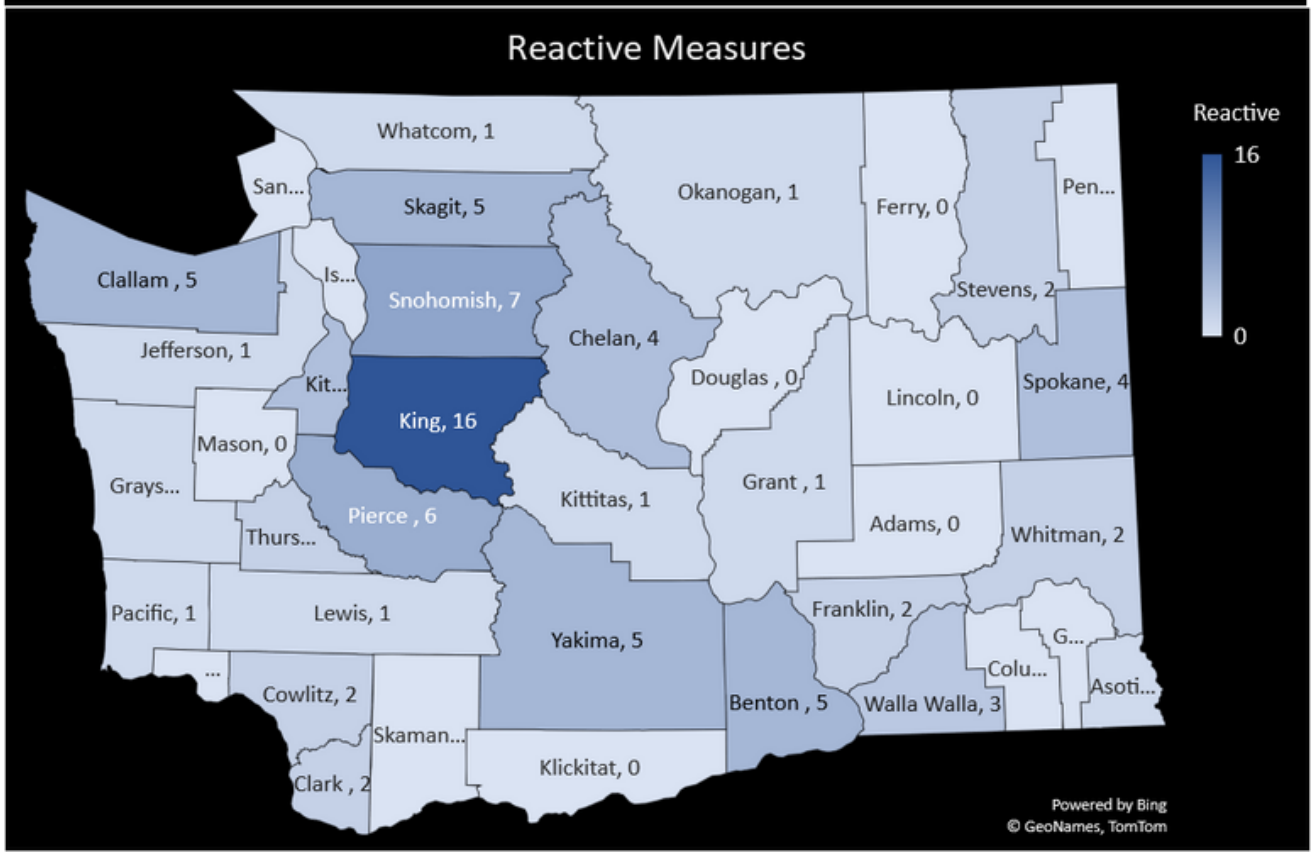
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CONCLUSION

Thank you for the opportunity to review the Critical Incident Stress Management (CISM) Program. During this research, many findings were revealed regarding the lack of information surrounding CISM and other mental health resources for first responders. It was discovered that barriers existed and prevented many first responders from using the program.

A few of the barriers are listed below:

- 27 % stated no barriers
- 23% stated the barriers to utilizing CISM was time, scheduling, and access
- 19% cited resources
- 18% cited lack of trust of a third party and stigma surrounding mental health

The ability to implement additional resources for mental health in law enforcement is paramount. 62% of respondents said there was no available measurement of the effectiveness of their stress management programs. With CISM, 45% are not measured for the effectiveness of the programs. Based on the information above, it is crucial to add a few items to the implementation of wellness programs.

Listed below are a few recommendations for your consideration:

- Provide a way to measure the success of each provided platform/resource
- Have multiple wellness resources/recommendations for officers to select from
- Work to remove the stigma surrounding mental health
- Consider providing shared MHP embedded in law enforcement facilities (Issaquah and Redmond Police Departments have used this model)
- Provide a modern, holistic approach to mental health within the law enforcement community
- Make sure all agencies are trained in trauma informed response

WSCJTC is committed to collaborating with legislators, mental health professionals and law enforcement to provide easy access to mental health resources. Through this study we recognize the lack of attention this sensitive subject has received. After experiencing a pandemic and the social justice uprising, we are compelled to look at this matter through a more sensitive and critical lens. From 2021-2022, WSCJTC will be taking a comprehensive look at programs across the state and developing in-depth, actionable recommendations for the advancement of wellness programs. This information will be compiled in a follow-up report to the legislature in July 2022.

Olympia PD Officer Manning posing with mural in West Olympia during height of COVID Pandemic 2020.