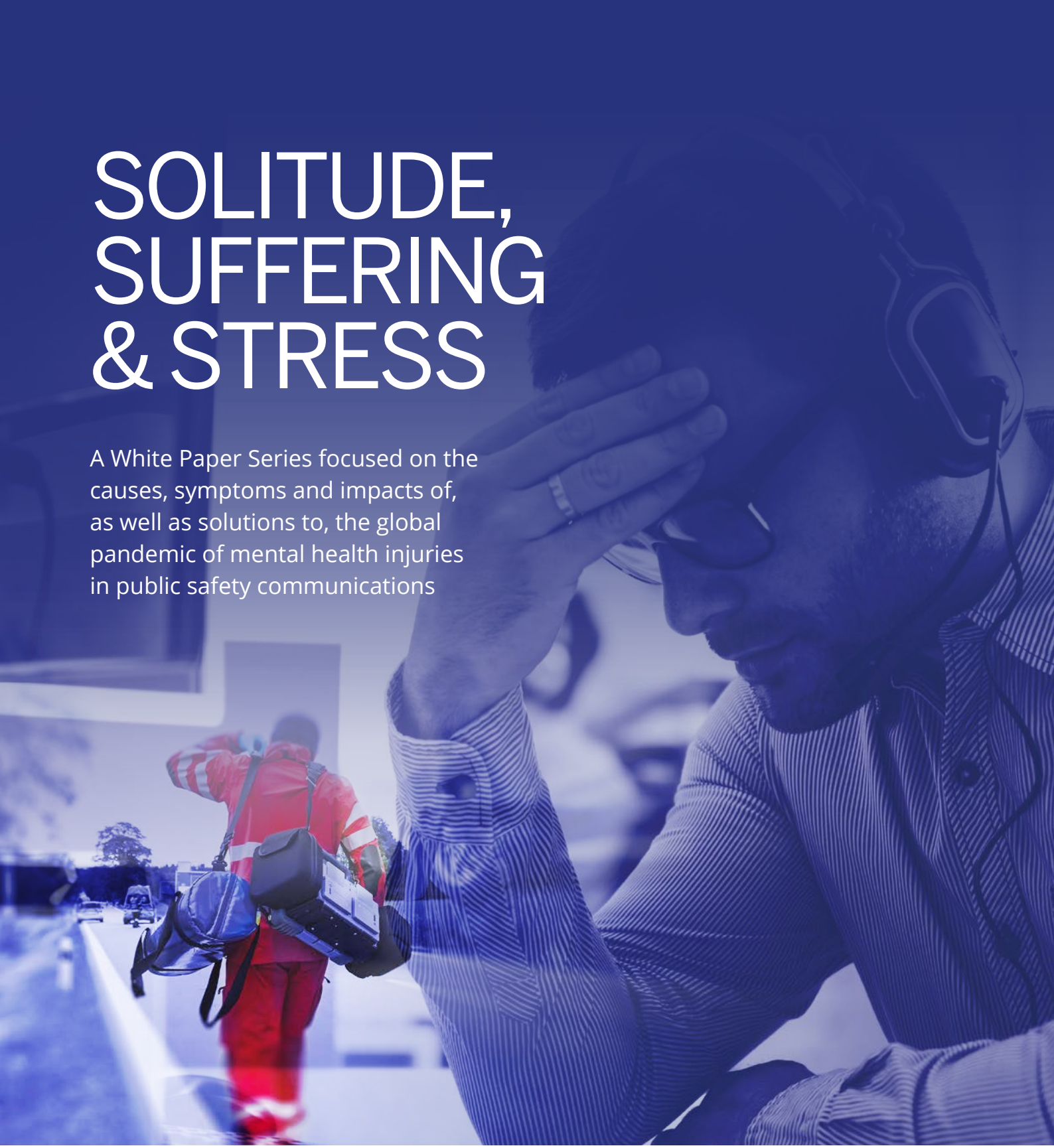
SOLITUDE, SUFFERING & STRESS

A White Paper Series focused on the causes, symptoms and impacts of, as well as solutions to, the global pandemic of mental health injuries in public safety communications



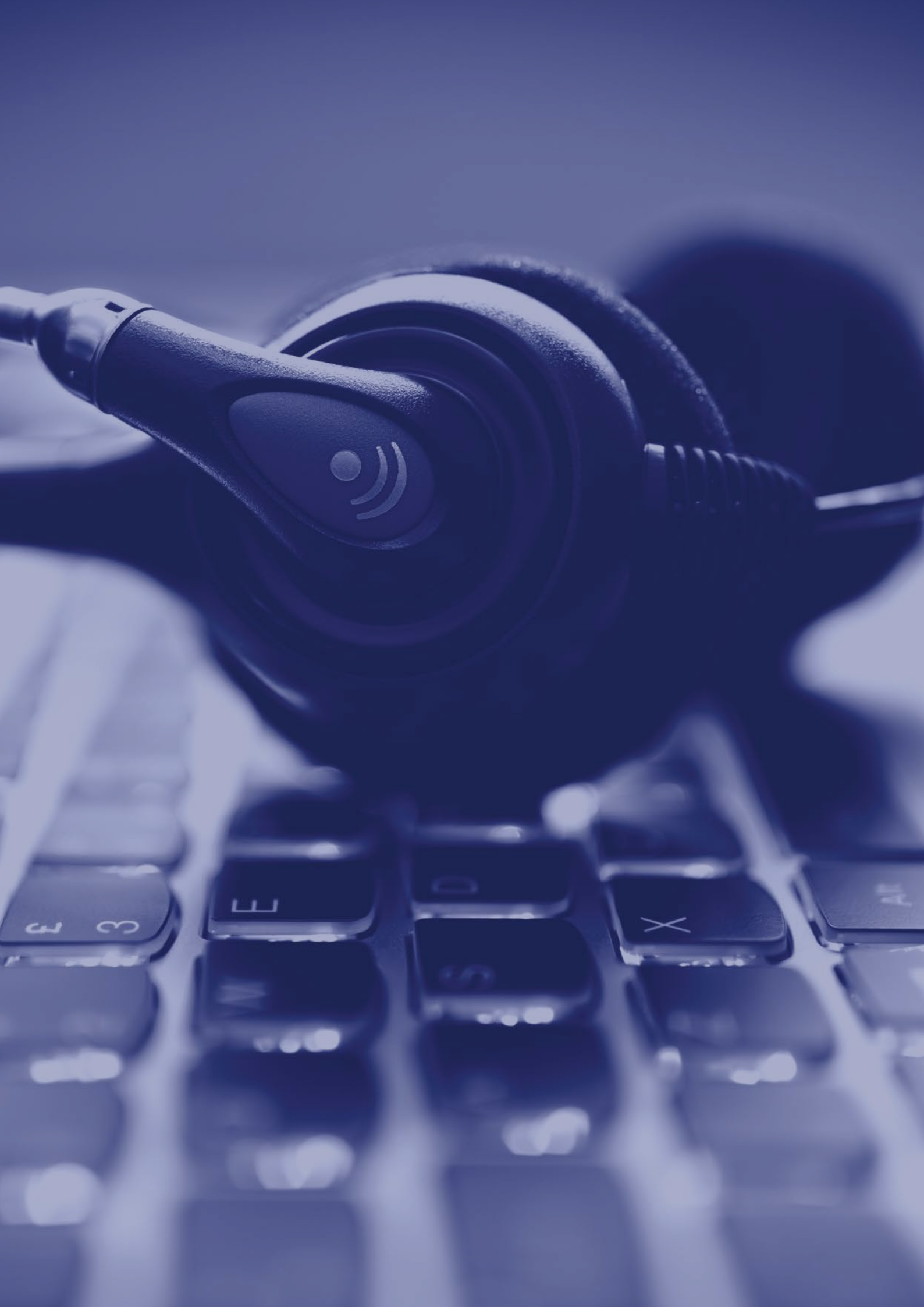
BRITISH APCO

Working in Partnership to Improve Public Safety Technology

BAPCO WHITE PAPER SERIES

No 02:2020: The Warning Signs

September 2020



CONTENTS

ABOUT THE AUTHORS

Cindy Sparrow, Director, Consort Strategy Ltd

Cindy is an international consultant, speaker, coach, trainer and writer. During her 24-year career in Emergency Services she worked frontline as a paramedic in ground and flight Emergency Medical Services (EMS); in the 9-1-1 Emergency Communications Centre as a Dispatcher for police, fire and EMS; and from 2006 to 2020 in senior leadership roles within the industry.

Before retiring in March 2020, she served for six years as Deputy Chief with Red Deer Emergency Services (RDES). She remains involved with industry associations and is the Immediate Past President of the Association of Public Safety Communications Officials Canada (APCO Canada); a former Director with the Alberta E9-1-1 Advisory Association; and is a member of the Canadian NextGen 9-1-1 Coalition; the Collaborative Coalition of International Public Safety (CCIPS); and is a Trustee of UK charity, Embrace Child Victims of Crime.

Cindy's passion is people and is committed to inspiring and facilitating human transformation and creating positive change by empowering and supporting people in realizing excellence. She is the newest Director and Partner of international consulting firm, Consort Strategy Ltd. She leads the North American portfolio and in doing so continues to pursue her passion for helping public safety organizations in developing and fostering innovation in leadership, strategy and business development.

Andrew Chamberlain, Managing Director, Consort Strategy Ltd

Andrew is a former association CEO and now MD of Consort Strategy, a consultancy firm specialising in leadership development, good governance, organization improvement and business growth. For 15 years he held C-suite leadership positions in professional associations and membership bodies across the UK.

He travels internationally to provide specialist support on non-profit governance, strategy, leadership and management. He is the founder of the Cambridge Governance Symposium; author of the NETpositive Governance™ model; co-host of the bi-monthly podcast *Association Transformation* and the weekly podcast *Good Enough for Jazz* (both available on Apple podcasts).

He is a long-term sufferer and survivor of depression that has resulted from several mental health injuries experienced throughout his professional and personal life. He is a vociferous advocate of mental health awareness and wellbeing, irrespective of professional contexts or social norms.

ABOUT BAPCO

The British Association of Public Safety Communications Officials (BAPCO) is acknowledged as the leading UK-based association for all professionals using or developing public safety technology. It is a growing community whose extensive knowledge and expertise in public safety technology is based on members' collective development, use and delivery of real-life public safety solutions. BAPCO is an independent, member-focused not-for-profit association with charitable status working to improve emergency services and public safety communications and information technology for everybody's benefit.

BRITISH APCO
Working in Partnership to Improve Public Safety Technology

DISCLAIMER

The opinions and information provided in the white paper are offered in good faith. Whilst we make every attempt to ensure the information contained in this white paper is correct, we are unable to guarantee the accuracy or completeness of any information contained herein.

BAPCO members, their employees and agents will not be responsible for any misinterpretation, misunderstanding or loss, however arising, from the use of, or reliance on this information.

INTRODUCTION

Public safety communications professionals (PSCs), the people who answer 3-digit and other emergency calls from the public, render lifesaving assistance, and deploy emergency resources to a scene, are routinely exposed to trauma through their day-to-day duties. Acutely and cumulatively, this trauma impacts the mental health and well-being of these professionals. Often, their work causes them to suffer mental health injuries, also known as operational stress injuries, which can lead to a multitude of disorders, such as anxiety, depression, vicarious traumatization and compassion fatigue, burnout, substance abuse, post-traumatic stress disorder (PTSD), suicidal ideation, and fatally, suicide.[1]

In a 2018 study[2] of the Canadian profession, more than half of PSC's who responded screened positive for one or more mental health injuries or disorders. It is clearly not a matter of if a PSC will suffer an operational stress and injury, but at what point during their career will a PSC be exposed to trauma and a potential operational stress injury.

Even though the nature of the work sustains an environment predisposed to trauma exposure, a distinct lack of awareness or understanding of mental health injuries endures within the profession; and without adequate training or guidance, it still proves difficult for leadership and management teams, as well as individuals and their colleagues, to identify the warning signs of a developing mental health disorder or operational stress injury. Consequently, a PSC's suffering can go undiagnosed, creating longer lasting problems or sometimes permanent harm to their health and well-being. It is imperative therefore that the symptoms of an operational stress injury are more widely recognised; and a broader understanding of how to support colleagues, or where to find support for their condition is equally critical if the profession is to succeed in addressing the global pandemic of mental health injuries in public safety communications.

In a 2018 study[2] of the Canadian profession, more than half of PSC's who responded screened positive for one or more mental health injuries or disorders.

COMMON MENTAL HEALTH INJURIES AND DISORDERS

Frontline communications specialists are routinely exposed to exceptional circumstances and on-the-job stressors[3] which combine to realise significant negative physical and psychological outcomes, manifesting as an amalgamation of complex mental, emotional and social disorders.

Anxiety

Anxiety is symptomatic of many mental health injuries but is also a serious condition in itself, caused by the invariable challenges and pressures of the job. Anxiety can present in a variety of ways but in relation to emergency communications, common symptoms include restlessness; tension; rapid heart rate; weakness or lethargy; difficulty focusing or thinking clearly; insomnia; digestive problems; and avoidance of issues that trigger the anxiety.

Burnout

Burnout is a special kind of job strain, resulting from prolonged stress. It leads to physical, emotional and/or mental exhaustion and often leaves a sufferer feeling powerlessness and with low job satisfaction. In the context of call-handlers and dispatchers, a combination of scenarios can easily emerge: In an emergency situation, dispatchers can only help to a certain degree; and if the frontline responders do not arrive in time, the PSC must listen to the caller succumb to their situation, leaving the PSC feeling helpless. When combined with the patterns of long shifts, mandatory overtime and unremitting calls, it is understandable why a call-handler will feel overwhelmed; and there is no time for recovery - when a call-handler must put down the phone after hearing someone have a heart attack and then swiftly answer the next call, perhaps from someone screaming that they have lost their child, and then move on to another critical situation, maybe a traffic accident with multiple casualties, it is no wonder that these conditions can begin to shape a PSC's personal circumstances. Sufferers can experience any combination of symptoms, including habitual cynicism or criticism of work; trouble applying themselves at the job; irritability or impatience with colleagues and, sometimes callers; loss of concentration; lack of productivity or satisfaction in their work; disillusion with the job; using food, drugs or alcohol to feel better (or to simply not feel); trouble sleeping or a change in sleeping habits; and unexplained headaches, stomach problems, or other physical complaints.

> In an emergency situation, dispatchers can only help to a certain degree; and if the frontline responders do not arrive in time, the PSC must listen to the caller succumb to their situation, leaving the PSC feeling helpless.

Depression

The World Health Organisation (WHO) describes depression as a common mental disorder affecting more than 264 million people worldwide. It is characterized by persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities. It can disturb sleep and appetite; and tiredness and poor concentration are common. Depression is a leading cause of disability around the world and contributes greatly to the global burden of disease. The effects of depression can be long-lasting or recurrent and can dramatically affect a person's ability to function and live a rewarding life.[4] In the context of emergency communications, common symptoms include feelings of hopelessness or pessimism; feelings of guilt or helplessness; difficulty concentrating; overeating and weight gain; thoughts of death or suicide; and, in the most extreme cases, suicide.

Post-traumatic stress disorder

Average levels of reported PTSD symptoms among call-handlers and dispatchers have ranged from sub-clinical levels[5] to meeting criteria for probable PTSD. The prevalence of PTSD among call-handlers and dispatchers has ranged from 3.5% in an initial study (Pierce & Lilly, 2012) to 24.4% in a larger study from across the US (Lilly & Allen, 2015)[6] . PTSD has four symptom clusters: avoidance (avoiding thoughts, memories or feelings that bring back details of a difficult call); numbing (detaching, adopting a viewpoint that the world is a bad place); hypervigilance (easily startled, on edge, difficulty sleeping and concentrating); flashbacks (re-experiencing the details, thoughts, memories and feelings from the call that come up recurrently).[7]

Suicide and suicidal behaviours

Levels of suicide, suicidal ideation (thoughts about and planning suicide), and suicide attempts are higher among first responders compared to the general public.[8] First responders under the age of 30, women, and those without a spouse or significant other reported higher levels of suicidal behaviour; and in a Canadian study, Carleton et al (2018) asserted that along with paramedics and correctional workers, PSCs reported higher levels of suicidal behaviours than other first responders. Given that PSCs generally, and female PSCs specifically report higher suicidal behaviours, the majority of the workforce is potentially at risk and therefore mental health training and support are imperative, particularly programs that recognize and provide skills to address suicide and suicidal behaviours.

Substance abuse

Substance abuse and mental health disorders such as depression and anxiety are closely linked, although one does not necessarily directly cause the other. Abusing substances such as marijuana or methamphetamine can cause prolonged psychotic reactions, while alcohol can make depression and anxiety symptoms worse[9]:

- **Alcohol and drugs are often used to self-medicate the symptoms of mental health problems.** People often abuse alcohol or drugs to ease the symptoms of an undiagnosed mental disorder, to cope with difficult emotions, or to temporarily change their mood. Unfortunately, self-medicating with drugs or alcohol causes side effects and in the long run often worsens the symptoms they initially helped to relieve.

- **Alcohol and drug abuse can increase the underlying risk for mental disorders.** Since mental health problems are caused by a complex interplay of genetics, the environment, and other factors, it is difficult to say if abusing substances ever directly causes them. However, if an individual is at risk of developing a mental health disorder, abusing alcohol or drugs may push them over the edge. For example, there is some evidence that those who abuse opioid painkillers[10] are at greater risk for depression, and heavy cannabis use has been linked to an increased risk for schizophrenia.

- **Alcohol and drug abuse can make symptoms of a mental health problem worse.** Substance abuse may sharply increase symptoms of mental illness or even trigger new symptoms. Abuse of alcohol or drugs can also interact with medications such as antidepressants, anxiety medications, and mood stabilizers, making them less effective at managing symptoms and delaying your recovery.

Meta-analyses have shown deficits in short-term memory, sustained attention, and psychomotor speed among individuals who drank heavily the day before[11]. Further, a meta-analysis of studies comparing individuals with and without alcohol use disorder demonstrated that alcohol use disorder is associated with greater deficits in planning, problem solving, and response inhibition[12], reflecting skills that are at the very centre of a PSC's work.

Vicarious trauma (secondary traumatic stress)

Vicarious trauma (VT), also referred to as secondary traumatic stress (STS) is described as the indirect trauma that can occur when we are exposed to difficult sounds, images, and stories second-hand.[13] VT and STS can affect any professional who works in a high stress and trauma exposed environment. For PSCs, whilst they are not directly on scene witnessing the trauma, they are experiencing it indirectly through the caller first hand while it is occurring. In any case, whether direct or indirect, it is still trauma exposure and has impacts on individuals involved. Due to constant exposure to trauma and injustices against and the suffering of humans, VT can cause PSCs to experience a significant shift in world view: their fundamental beliefs about the world can be changed and they may begin to see it as a scary and untrustworthy place. Professionals in helper fields who are impacted by VT and STS exhibit symptoms of PTSD, without having ever been directly exposed to trauma. VT symptoms are often reported as negative self-image, emotional exhaustion, loss of pleasure, increased sadness, change in appetite, guilt, learned helplessness, and hopelessness.

Compassion fatigue

Compassion fatigue is "...the profound emotional and physical erosion that takes place when helpers are unable to refuel and regenerate."[14] Like VT, PSCs suffering compassion fatigue will experience a change in their fundamental beliefs about the world due to the constant exposure to trauma and human suffering. It is a result of the acute and cumulative stresses of witnessing injury or death of those seeking help (in person or via the telephone), experiencing injury or the death of fellow first responders, dealing with victims of crime, disaster, accident, injury and illness. Compassion fatigue is much more than burnout or being tired and overworked. It is often present due to moral distress, caused by a conflict between our values and the work we are required to do.[15] Aside from first responders, anyone working in a support profession is at risk of vicarious or secondary trauma, which can lead to compassion fatigue. It is however aggravated by long hours, shift work, high exposure to stressors and trauma, and compounded when PSCs have already suffered mental health injuries due to occupational stress.

SYMPTOMS OF MENTAL HEALTH INJURY & ILL-HEALTH

The effects of operational stress and trauma are diverse, and symptoms present differently for different people. Individuals who are injured or ill may present with all, or only some of the symptoms:

HOW TO RECOGNISE THE SIGNS AND SYMPTOMS OF YOUR STRESS

Physical	Emotional	Cognitive	Behavioural
• Change in sleep patterns • Change in appetite • Shallow or rapid breathing • Headaches • Muscle tension & soreness • Increased heart rate / palpitations • Stomach upset	• Shock or numbness • Anger toward others involved • Fear • Depression or low mood • Guilt / frustration • Sadness / tearful • Feeling unsafe of vulnerable • Loneliness	• Confusion • Difficulty concentrating • Difficulty remembering details of events • Feeling mentally "foggy" • Impulsivity • Over-focused on an activity	• Withdrawal from others • Angry outbursts • Irritability • Crying • Decreased energy / ambition • Relationship conflicts • Increased use of alcohol and/or medications • Fear of being alone

HOW TO RECOGNISE THE SIGNS AND SYMPTOMS OF STRESS IN OTHERS

Physical	Emotional	Cognitive	Behavioural
• Weight loss or gain • Grinding teeth • Frequent colds or infections • Dizziness • Palpitations • Nausea • Fatigue • Self-neglect • Change of appearance • Nervous	• Irritability • Becoming angry with others too easily • Depressed / tearful • Frightened • Worried or anxious • Panic attacks • Impatient • Mood swings • Constant negativity • Extra sensitive to criticism • Lack of confidence	• Poor concentration • Unable to listen to others • Memory lapses • Confusion / disorientation • Difficulty making simple decisions • Poor planning and task execution • Less intuitive or creative • Becoming vague • Easily distracted • Reckless decision-making	• Increased smoking • Increased use of alcohol • Restlessness / fidgeting • Absence from work • Lack of motivation or commitment • Aggression • Prone to accidents • Social withdrawal • Loss of sense of humour • Defensive • Becoming a workaholic

Operational stress injuries and mental ill-health can present as complex combinations of these symptoms and therefore it is critical that PSCs and workplace leaders be aware of the indicators and psycholinguistics of injuries or disorders.

The warning signs

There are several signs and symptoms that appear when someone is suffering an operational stress injury or disorder that include changes in mood, thinking and attitude, behaviour and performance, and physical changes. These can be gauged along the *Mental Health Continuum Model* (MHCM).[16] The MHCM was designed originally for Canadian soldiers and was soon shared with the Canadian first responder community. The MHCM allows PSCs to easily assess themselves or others on the scale of injury based on what they are experiencing. This eliminates the need for "diagnosing" or stigmatizing labels and rather just provides the means to identify signs and indicators and utilise techniques to address them, and/or seek assistance and support for treatment.

The Mental Health Continuum Model

HEALTHY	REACTING	INJURED	ILL
• Mental health • Normal functioning • Recovery from mental illness	• Common and self-limiting distress	• More severe functional impairment	• Diagnosable mental illness • Severe and persistent functional impairment

This is a powerful tool for PSCs, enabling them to identify their current mental state and helping to address their well-being by providing the tools and appropriate direction for seeking support. The MHCM is divided into four phases and moves from "healthy (green), to reacting (yellow), to injured(orange), to ill (red)" along a gradient. It is colour coded to indicate increasing levels of symptoms and injury across each phase.

HEALTHY	REACTING	INJURED	ILL

SIGNS & SYMPTOMS

HEALTHY	REACTING	INJURED	ILL
• Normal mood fluctuations • Calm/confident • Good sense of humour • Taking things in stride • Can concentrate/focus • Consistent performance • Normal sleep patterns • Energetic, physically well, stable weight • Physically and socially active • Performing Well • Limited alcohol consumption, no binge drinking • Limited/no addictive behaviours • No trouble/impact due to substance abuse	• Nervousness, irritability • Sadness, overwhelmed • Displaced sarcasm • Distracted, loss of focus • Intrusive thoughts • Trouble sleeping, low energy • Changes in eating patterns, some weight gain/loss • Decreased social activity • Procrastination • Regular to frequent alcohol consumption, limited binge drinking • Some to regular addictive behaviours • Limited to some trouble/impact due to substance use	• Anxiety, anger, pervasive sadness, hopelessness • Negative attitude • Recurrent intrusive thoughts/images • Difficulty concentrating • Restless, disturbed sleep • Increased fatigue, aches and pain • Fluctuations in weight • Avoidance, tardiness, decreased performance • Frequent alcohol consumption, binge drinking • Struggle to control addictive behaviours • Increase trouble / impact due to substance us	• Excessive anxiety, panic attacks, easily enraged, aggressive • Depressed mood, numb • Non-compliant • Cannot concentrate, loss of cognitive ability • Suicidal thoughts/intent • Cannot fall asleep/ stay asleep • Extreme weight fluctuations • Withdrawal, absenteeism • Can't perform duties • Regular to frequent binge drinking • Addiction • Significant trouble/impact due to substance use

Under each phase of the MHCM an outline of signs and indicators is offered to assist with self-assessment. Further, a set of actions is listed to assist with addressing and/or treating the signs and indicators in that phase. It is important to note that PSCs can move back and forth along the Continuum, depending on the injury, signs and indicators and if action to reduce injury and/or receive treatment are taken.

HEALTHY	REACTING	INJURED	ILL

ACTIONS TO TAKE AT EACH PHASE OF THE CONTINUUM

HEALTHY	REACTING	INJURED	ILL
• Focus on task at hand • Break problems into manageable tasks • Controlled, deep breathing • Nurture a support system	• Recognise limits, take breaks • Get enough rest, food, exercise • Reduce barriers to help-seeking • Identify and resolve problems early • Example of personal accountability	• Talk to someone, ask for help • Tune into own signs of distress • Make self-care a priority • Get help sooner, not later • Maintain social contact, don't withdraw	• Follow care recommendations • Seek consultation as needed • Respect confidentiality • Know resources and how to access them

Recognizing signs early and having the training, tools and support in place to address them is key to ensuring operational stress does not become a long-term injury, and that mental health injuries are identified and treated early. The sooner a person has access to support and treatment, the sooner they recover, whilst also minimizing some of the longer-term impacts.[17]

BARRIERS TO PROGRESS

A culture of honesty and openness around mental health has rapidly emerged during the last decade. We increasingly hear candid conversations amongst celebrities, politicians and public figures about their own struggles with maintaining their mental well-being, and this certainly helps to permeate discussion amongst the wider public and to "normalise" the challenges individuals can face with their mental health. Stigma around depression and other mental illness does however still exist and just as it can be higher in some cultural groups, so too it can linger in certain professions, and this has been the case in public safety communications.

Stigma and Discrimination

Stigma involves three elements: a lack of knowledge (ignorance), negative attitudes (prejudice) and people behaving in ways that disadvantage the stigmatised person (discrimination).[18] The stigma related to mental health problems is particularly severe and widespread. There are two main types: social stigma and self-stigma. Social stigma, also called public stigma, refers to negative stereotypes of those with a mental health problem. These stereotypes come to define the person, mark them out as different and prevent them being seen as an individual. Social stigma is also associated with discrimination; for example, a person with a mental health problem may find that others, including friends and colleagues, avoid them.

There is general agreement amongst the public safety community that levels of stigma around mental health have decreased in recent years and that individuals and managers are generally more open to discussing mental health than in the past. The range and diversity of mental health conditions is no more widely understood and accepted in North America than in the UK but where we find in the US and Canada an increasingly open debate about the mental health of call-handlers and dispatchers is underway, in the UK a culture of "just get on with it" still lingers: participants in Mind's four-year *Blue Light Programme* (2015-19)[19] talked of experiencing organisational cultures that perpetuate the view that because dealing with distressing incidents and stressful situations is fundamentally the call-handler's job, it is assumed that personnel should be able to handle those situations with little or no support for their mental wellbeing.

Studies in Canada have shown that up to 50% of public safety personnel meet the criteria for mental health disorder diagnosis, and PSCs specifically screened at 48.4%[20], demonstrating parity between call-handlers and frontline responders. These studies also support the concept that it is the operational stressors and exposures to trauma in the profession that contribute to mental health injury in PSCs, rather than a lack of individual ability to handle stress. In short: it is the job, not you.

Organizational culture and structures can deter PSCs from seeking support: a culture which fails to normalise mental health discussions will influence an individual's decision to access mental health care. In these environments, concerns about how they will be viewed by colleagues and leaders if they speak up or access care are genuine. For example, in one study, a large number of first responder participants reported suspicion of co-workers "playing the system" when taking time off (medical leave) to address their mental health injuries.[21] In these circumstances it is hardly surprising that individuals feel unable to seek help. Stigma among PSCs still prevails in many environments and can create situations where employees will deny

"Studies in Canada have shown that up to 50% of public safety personnel meet the criteria for mental health disorder diagnosis, and PSCs specifically screened at 48.4%[20], demonstrating parity between call-handlers and frontline responders."

their mental health needs and avoid seeking help when they need it most. At the heart of it is their shame; that they will be cut off from the group if they are found out. The survival instinct in all of us is programmed to need group belonging, and it is fear of the loss of connection through lack of acceptance within a group that fuels an individual's silence and suffering. Most significantly, it is these situations that foster suicidal feelings.

Action must be taken to further reduce the stigma of mental illness. Stigma and discrimination are of course linked to much broader societal and cultural issues, but employers can and should nonetheless make considerable efforts to supporting their staff to understand the causes, symptoms, and relief of mental health disorders.

Trauma and Culture: "The way we do things around here"

New employees learn old, ineffective, and often harmful ways of operating in the culture if effort has not been made to create a supportive culture and environment where mental health is a priority.

Stoic Service Culture

Stoicism has been the prevailing approach to managing difficult incidents and operational stress for many years in the public safety profession. Stoicism is defined in the Oxford Dictionary as "the endurance of pain or hardship without the display of feelings and without complaint". It is a habit which encourages PSCs to master the suppression of their emotional pain, pushing it down and "getting on with it" rather than processing the emotions they experience because of the trauma to which they are exposed. A stoic service culture is one that values discipline, competition, aggression and physical strength. Research and emerging cultures of supporting good mental health combine to demonstrate that stoicism is no longer an appropriate practice in public safety communications, and in fact can compound the effects of operational stress and mental health injury, intensifying stigma, and further decreasing the likelihood of PSCs reaching out when they need help.

Stoicism and clinical detachment

Emotional detachment, when used purposefully, can be helpful for any PSC who is dealing with an emergency and must remain temporarily unemotional so that they can focus on their duties. However, they should not be expected to function in that state all of the time. Often stoicism and a stoic workplace culture reinforces the idea that PSCs must never openly show signs of grief after a call, and that they should be able to withstand the rigors of the profession without incident or complaint and simply go on to the next call. This can lead to a near permanent state of emotional detachment as a means of coping with not only the stressors at work, but often in other parts of their lives. A coping strategy invariably becomes clinical (emotional) detachment, characterized by emotional "numbing", reduced ability to express emotion, lack of attention or being seemingly preoccupied, avoidance behaviour, and an inability or unwillingness to connect with others emotionally. This does nothing to maintain the positive psychological longevity of PSCs, and often is present with other mental health disorders.

> Often stoicism and a stoic workplace culture reinforces the idea that PSCs must never openly show signs of grief after a call...

Lack of professional designation, classification or recognition

In many control rooms across the globe, PSCs are not considered protective or essential services, resulting in restricted access to resources and funding that are made available to support the mental health and wellbeing of frontline responders. Therefore, public safety communication centres and control rooms are left to determine their own approaches to supporting their people and with limited budgets, training and support for addressing mental health is often viewed as a "nice to have" rather than a "need to have".

CALL TO ACTION

The industry and wider society can no longer turn a blind eye to the impacts on PSCs of their day-to-day operational duties. Research demonstrates that this issue is not about individuals' ability to "handle" the job but rather it is continuous exposure to trauma in the work environment which fuels the silent pandemic of mental health injuries within the industry. In their Canadian study, Carleton et al (2018) assert that nearly 50% of PSCs screened positive for a mental health injury or disorder due to the demands of their work. Our profession is experiencing a mental health injury crisis of global proportions, and it is time for the industry, civic leaders, and our governments, to address the causes and impacts of, and solutions to this mental health crisis.

> 50% of PSCs screened positive for a mental health injury or disorder due to the demands of their work.

OTHER TITLES IN THIS SERIES

Subsequent titles in this series address the symptoms and impacts of and solutions to the pandemic of mental health injuries in public safety communications, providing the industry with insights on understanding and tackling a global contagion that risks significantly undermining the success, value and impact of public safety communications and this vital profession:

No 01:2020: Causes of a silent pandemic (published August 2020)

No 03:2020: The hidden costs (published October 2020)

No 04:2020: Realising good cognitive health (published November 2020)

ACKNOWLEDGEMENTS

Many colleagues have provided insights that have helped to shape this series of white papers and in particular we want to acknowledge the following, who have been instrumental in guiding our development of this narrative:

Dr Stephen Czarnuch, Assistant Professor, Memorial University of Newfoundland

Stephen's PhD focused on human tracking, ambient intelligence and automated task assistance systems, designing systems to support the loss of cognition associated with dementia in a real-world, home environment. In 2015 he joined Memorial University as an assistant professor, jointly appointed to the Department of Electrical Engineering and the Discipline of Emergency Medicine in the Faculty of Medicine. He is a Scholar in Residence at the Canadian Institute for Public Safety Research and Treatment and as such is part of the team pioneering Canadian research into the causes and responses to public safety personnel trauma.

Dr Michelle Lilly, Associate Professor, Northern Illinois University

Michelle is a licensed clinical psychologist in Illinois and is trained in evidence-based treatments for PTSD, depression, anxiety, and other conditions, and has experience in delivering training and intervention at both individual and group levels. She has studied the physical and mental health of public safety professionals over the past decade and is among the first to publish data on the mental and physical health of 9-1-1 professionals. In 2019 she has received State funding to support the development and distribution of her Saving Blue Lives training on PTSD, suicide, peer support, and resilience.

Monica Million, Executive Director, Colorado 9-1-1 Resource Center

Monica has worked in the 9-1-1 industry for 18 years. She began her career as a 9-1-1 Telecommunicator, worked her way to the Center Training Officer, Supervisor and ultimately the Operations Manager of the Grand Junction Regional Communication Center. She holds the Emergency Number Professional Certification and has a BA from California State University, Long Beach. She is the Immediate Past President of the US National Emergency Number Association (NENA); a founding member of the Collaborative Coalition of International Public Safety (CCIPS); and the driving force behind NENA's Continuum Initiative, a comprehensive approach to promoting wellness in the 9-1-1 industry.

Ian Thompson, Chief Executive, British APCO

Ian was appointed Chief Executive Officer in December 2016 after retiring from a successful 30-year career in the police. Previously a volunteer member of the BAPCO Executive Committee for a number of years, Ian has a strong background in public safety critical communications and IT from his time in the police service. He has changed the focus of the association from blue light critical communications to a more inclusive membership from across all areas of public safety technology. He is a founding member of the Collaborative Coalition of International Public Safety (CCIPS) and a leading figure in defining international conversations about mental health injuries and wellbeing in public safety communications.

REFERENCES

[1]Carleton, R. N., Afifi, T. O., Turner, S., Taillieu, T., Duranceau, S., LeBouthillier, D. M., Sareen, J., Ricciardelli, R., MacPhee, R. S., Groll, D., Hozempa, K., Brunet, A., Weekes, J. R., Griffiths, C. T., Abrams, K. J., Jones, N. A., Beshai, S., Cramm, H. A., Dobson, K. S., … Asmundson, G. J. G. (2018). Mental disorder symptoms among public safety personnel in Canada. The Canadian Journal of Psychiatry / La Revue Canadienne de Psychiatrie, **63**(1), 54–64.

[2]Carleton et al., (2018)

[3]Sparrow, C. & Chamberlain, A. (2020), Solitude, Suffering & Stress: Causes of a silent pandemic, British APCO White Paper, No 01:2020.

[4]World Health Organisation (2020) [viewed 23 September 2020]. Available at www.who.int/news-room/fact-sheets/detail/depression

[5]Pierce, H., & Lilly, M. M. (2012). Duty-related trauma exposure in 911 telecommunicators: Considering the risk for posttraumatic stress. Journal of Traumatic Stress, **25**(2)

[6]Lilly, M.M., & Allen, C.E. (2015). Psychological inflexibility and psychopathology in 9-1-1 telecommunicators. Journal of Traumatic Stress, **28**(3), 262–266.

[7]Raskin, A. (2016) PTSD and Emergency Telecommunicators https://iaedjournal.org/ptsd-in-911-communications-qa/

[8]Carleton et al., (2018)

[9]www.helpguide.org/articles/addictions/substance-abuse-and-mental-health.htm

[10]www.helpguide.org/harvard/opioid-addiction.htm

[11]Gunn, C., Mackus, M., Griffin, C., Munafo, M. R., & Adams, S. (2018). A systematic review of the next- day effects of heavy alcohol consumption on cognitive performance. Addiction (Abingdon, England), **113**(12), 2181–2193.

[12]Stephan, R. A., Alhassoon, O. M., Allen, K. E., Wollman, S. C., Hall, M., Thomas, W. J., … Grant, I. (2017). Meta-analyses of clinical neuropsychological tests of executive dysfunction and impulsivity in alcohol use disorder. The American Journal of Drug and Alcohol Abuse, **43**(1), 24–43.

[13]O'Handley, A. (2017) Warning signs of vicarious trauma www.tendacademy.ca/category/vicarious-trauma/

[14]Mathieu, F., (2019) What is Compassion Fatigue? www.tendacademy.ca/what-is-compassion-fatigue/

[15]Mathieu (2019)

[16]Canadian Department of National Defence, The Mental Health Continuum and Road to Mental Readiness (R2MR) Program.

[17]The Department of National Defence, Calgary Police Service, and the Mental Health Commission of Canada, 2017. (The Mental Health Continuum and R2MR: Road to Mental Readiness Program were originally created by the Canadian Department of National Defence.), https://theworkingmind.ca/sites/default/files/resources/r2mr_poster_en.pdf

[18]Thornicroft G., Rose D., Kassam A. & Sartorius N., (2007). Stigma: ignorance, prejudice or discrimination. British Journal of Psychiatry. **190**, pp. 192-3.

[19]Mind, (2019b). Wellbeing and mental health support in the emergency services. Our learning and key recommendations for the sector. London: Mind. [viewed 19 December 2019]. Available at www.mind.org.uk/media/34555691/20046_mind-blue-light-programme-legacy-report-v12_online.pdf?_ga=2.174666402.1435300187.1576791355-7616030.1573742671

[20]Carleton et al., (2018)

[21]Ricardelli et al., (2020) Playing the system: Structural factors potentiating mental health stigma, challenging awareness, and creating barriers to care for Canadian public safety personnel

+44 (0)3303 327173 www.bapco.org.uk @BritishAPCO

BAPCO is a member of CC:IPS

INSPIRING GLOBAL INTEROPERABILITY AND ENHANCING PUBLIC SAFETY

consort

Delivered with the support of
Consort Strategy Ltd (www.yourconsort.com)

Jemma Pentney

Design by Jemma Pentney Graphic Design
& Illustration (www.jemmapentney.com)

NETpositive GOVERNANCE

A NETpositive Publication

Chemical free printing | Printed using vegetable litho ink | Printed on recycled paper | Printed with no waste to landfill