PSYCHOLOGICAL ASSESSMENT INCORPORATED

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RE: Peace Officer PTSI Workers' Compensation Presumption

Dear Mr. Lavigne,

As you know, the California Legislature unanimously passed Senate Bill 542 Stern, which contains a presumption for first responders who have developed Post-Traumatic Stress Disorder (PTSD), also known as Post-Traumatic Stress Injury (PTSI), as a result of their jobs. Workers' compensation presumptions for law enforcement (e.g., cancer, heart, and lower back) were created to recognize that various conditions occur as a result of the danger and hazardous exposure officers routinely face. Furthermore, because the occurrence of these injuries is disproportionately high among law enforcement compared to other members of the workforce, the Legislature has adopted these presumptions to encourage the filing of claims and put into place guidelines to ensure that they are accepted as quickly as possible.

Labor Code Section 3212.15, creates a presumption for PTSI developing as a result of working as a first responder. The presumption provides that the PTSI shall be presumed to *arise out of* and *in the course of* employment. Those qualifying shall be awarded full compensation for their injury, including medical care and disability indemnity.

What was accidentally omitted from that Bill was a presumption for dispatchers, or telecommunicators, who are integral to the first responder system. Dispatchers are most often the first point of contact for people in crisis, hearing sometimes horrific stories and working to make sure that police, fire fighters, and emergency medical responders are appropriately summoned. They use communication skills to assess emergency situations, remaining calm and poised, and staying in crisis situations with people until help can arrive. However, since they are not physically present, dispatchers must visualize the crisis scenario, which can be even more impactful.

In 2023, the opportunity for the new Senate Bill 623 extends the sunset on the PTSI for fire and police and extends the PTSI presumption for dispatch. It is my hope that the following information can assist with that extension.

Burnout, otherwise known as Complex Trauma or Vicarious Trauma, is a well-recognized and researched phenomena that includes a state of emotional, mental, and physical exhaustion brought on by prolonged or repeated stress. It takes a toll on many areas of an individual's life and can result in cynicism, loss of interest in previously enjoyed activities, and physical maladies. It is also often a precursor to development of PTSD/PTSI which includes a constellation of symptoms outlined in the Diagnostic and Statistical Manual, 5th ed., Text Revision (DSM-5-TR) (see Appendix A) that can include avoidance behavior, flashbacks, sleep disturbance and nightmares, and mood instability. Much of the research that discusses emergency medical personnel, including dispatchers, examines symptoms of burnout, in addition to PTSD.

It should be noted that acknowledgment of the detrimental physical, mental, and emotional impact of emergency work on dispatchers is not a new concept. Rosberg et. al., in 1988 conducted a study that suggested that dispatchers demonstrated higher level of symptoms of burnout then did patrol officers. Most research includes dispatchers with other emergency medical personnel, with finding overwhelmingly consistent in showing that all disciplines experience symptoms of burnout and PTSD. Several studies (Troxel, 2008; Pierce & Lilly, 2012; Lilly & Allen, 2015; Marshall & Gilman, 2015; Smith et. Al., 2019; Steinkopf et.al. 2018; Zaluski & Makara-Studzinska, 2022) have been conducted that directly evaluate symptoms in dispatchers, with consistent results. Emergency dispatchers experience greater rate of symptoms of burnout and PTSD, with some studies finding as many as 24% of those surveyed meeting criteria for PTSD. Smith, et. al. (2019) also draws attention to additional issues including the unique work environment contributing to at-risk physical health issues including obesity, headache, backache, insomnia, as well as elevated cortisol levels resulting in greater risk of heart disease. Golding et. al. (2017) outlines that the combination of traumatic calls, lack of control over high workload, and working in under-resourced and pressured environments are contributing factors to negative psychological health outcomes.

Further, several studies discuss the unique position of dispatchers being exposed to multiple calls without opportunity for breaks in between with inadequate debriefing, a technique well accepted and implemented by other emergency medical disciplines. Critical Incident Stress Debriefing has been around since 1983 (Mitchell, 2016) and allows for police, firefighters, and paramedics to have a safe place, with trained professionals, to discuss the details of the traumatic situation and their reaction to it. Research suggests that quick access to debriefing can actually mitigate or lessen the effects of PTSD, and yet dispatchers are not often afforded this resource.

No prevalence rates could be found to discuss the levels of high turnover or suicide rates among dispatchers, and it is possible that because this sub-group of emergency medical personnel is often overlooked or grouped in with others, that the current numbers for other disciplines can be extrapolated to dispatchers as well. What is obvious, however, is that dispatchers are an overlooked group that are taken for granted. As they are not the "face" of the responder, their "voice" gets lost in the crisis.

As the child of decorated Army war hero and medic, first responder, and paramedic, James Dempsey, I was privileged to grow up among the emergency medical personnel. Speaking from not just professional experience as a Qualified Medical Evaluator who has had the opportunity to evaluate emergency medical personnel, but personal experience, it is my sincere hope that this year the

California Senate will again unanimously vote to expand Senate Bill 623 to include dispatchers among those crucial to our emergency medical systems.

Thank you for the consideration.

Sincerely,

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# Appendix A

## Diagnostic and Statistical Manual, 5th ed., Text Revision (DSM-5-TR)

### Post Traumatic Stress Disorder

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
    1. Directly experiencing the traumatic event(s).
    2. Witnessing, in person, the event(s) as it occurred to others.
    3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
    4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
    1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
    2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** In children, there may be frightening dreams without recognizable content.
    3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
    4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
    5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
    1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
    2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
    1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).
    2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
    3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
    1. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
    2. Reckless or self-destructive behavior.
    3. Hypervigilance.
    4. Exaggerated startle response.
    5. Problems with concentration.
    6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.
G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:
**With dissociative symptoms:** The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted). **Note**: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

## Appendix B

### References

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