PROPONENT TESTIMONY ON SB 5

SENATE FINANCE COMMITTEE

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On Behalf of the National Association for the Mentally Ill

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Good morning, Chairman Oelslager and Members of the Finance Committee. Thank you very much for the honor of speaking to you today in support of SB 5. My name is Dr. Kathy Platoni. I am a licensed clinical psychologist in Ohio. For many years, I have been considered a subject matter expert on the subject of Post-Traumatic Stress Disorder by the US Army Reserve, the US Army, and the Ohio Military Reserve. I am the co-author and co-editor on 2 books about war trauma, PTSD, and treatment interventions and have published a multitude of scholarly articles in this arena. I have treated hundreds and maybe even thousands of Soldiers, veterans, police officers and firefighters for Critical Incident Stress, Acute Stress Disorder, and Post-Traumatic Stress Disorder for many decades, having served in the US Army/USAR for 34 years. I served as the Chief Psychologist for the US Army Reserve for 6 years. I served as a volunteer debriefer for NYPD twice in the weeks and months following 9/11. I lecture throughout the United States on subjects pertaining to war trauma, PTSD, and deadly force encounters. I am a survivor of the

Fort Hood Massacre and now, have a far more in depth and intimate knowledge of PTSD from the inside out. I conduct all the post-officer involved shooting/deadly force encounter evaluations for several police departments in Montgomery and Greene Counties. I am also the editor of a quarterly combat stress publication that deals directly with treatment issues as they pertain to PTSD and combat stress. I have been a member of the Southwest Ohio Critical Incident Stress Management Team for more than 15 years and with members of this highly trained team of volunteers, have conducted numerous debriefings in the aftermath of critical incidents.

Per Dr. Raymond Scurfield, one of this nation's leading experts on trauma and my co-author:

- Since the publication of the DSM-III in 1980 when PTSD was first introduced, it has NEVER been the case that PTSD occurs only in association with physical injuries. To reiterate, for at least the last 35 years, the official diagnosis of PTSD has never been limited to only occurring in association with physical injuries.

- I know of absolutely no professional journal publications or professional organizations that espouse such a limitation.

- The military and the VA do NOT limit diagnoses of PTSD to being associated only with physical injuries.

- Physical injuries are, of course, a known salient risk or precipitating factor for developing PTSD.

- To my knowledge, the professional literature overall indicates that the amount of exposure to trauma is the greatest single predictor for developing PTSD.

Harm to first responders' mental health is equally as important to consider, as physical health and is far too often overlooked because this kind of trauma doesn't bleed. Nevertheless, the presence of any psychological disorder and in this case, PTSD, may impair the ability of first responders to function. Several studies have revealed that after responding to disasters, first responders often experience elevated rates of depression, PTSD, and any other number of psychological disorders and injuries that may last days, weeks, months, years and decades without treatment. With relentless exposure to trauma, PTSD is likely to occur at a higher rate than in the general population because of exceedingly high levels of stress associated with their duties. Prevalent mental health conditions such as PTSD, which can be triggered by work-related traumatic events, can be as debilitating as physical injuries.

PTSD is a mental disorder that potentially follows one or more traumatic events where an individual experiences a potential or actual loss of life or experiences a sense of helplessness or horror. The regularity of these events, as evidenced by EMS, police and firefighters, may be cumulative and add to the risk of PTSD. Finally,, combined with untreated PTSD, such risk factors as stress, mental health problems, alcohol abuse, divorce or separation, and the presence of a firearm in the home, all contribute to the potential of intentional self-harm or suicide.

Without treatment, first responders are likely to be at greater risk for increasingly more intrusive and debilitating symptoms, which will result in decreased productivity and "man/women" hours. It is commonplace for those exposed to catastrophic life experiences to experience a host of highly disturbing and disquieting symptoms, which will ultimately impair them on the job. They may freeze, be unable to perform, be subject to flashbacks, intrusive recollections, panic attacks, severe anxiety and agitation, and a host of other very limiting symptoms, all of which have the potential to temporarily prevent them from performing on duty and in some cases, from even showing up to the scene.

When lives are at stake, this would be another tragedy waiting to happen. This is the perfect storm and a setup for excessive guilt and self-blame. It is also not at all unusual for those too impaired to perform to experience suicidal ideation and intent. Overall and in the big picture, failure to make treatment available equals risk of the loss of that employee due to time off, sick leave, and/or termination over time due to progressive decompensation and complete disability. I have seen combat multiple times and treated multitudes of Soldiers in the field for combat stress and PTSD, but oftentimes the battlefield of the streets is no different, however the exposure to trauma is prolonged and far more frequent, making exposure a more serious problem in terms of the likelihood of a PTSD diagnosis.

The bottom line is that if the state fails to do something today regarding the mental health of first responders, it will have long-term consequences at in increasingly higher costs to the State of Ohio. Finally, our first responders have our backs. They put their lives on the line for us every minute of every hour of every day. It's long past due time we had theirs.

PTSD treatment cannot occur without a formal evaluation, which should include, at the very least, a comprehensive clinical interview, history-taking, mental status exam, and psychometric assessment. Once a diagnosis is established, a treatment plan is necessary to determine the best goodness of fit for that particular patient.

In terms of co-occurring disorders or dual diagnoses of PTSD and chemical dependency disorders, it is very frequently the case that the onset of substance abuse problems is precipitated by the overwhelming need to self-anesthetize and NOT to feel. Psychic numbing is inherent in the diagnosis of PTSD. Practitioners should either have expertise in treatment of dual diagnoses or to work in conjunction with someone who does. The ERIN program in Cincinnati, for instance, is an effective and confidential service to help firefighters, police officers, EMS professionals, dispatchers and others to find a pathway of recovery from the devastating effects of alcohol and drug misuse.

Speaking of which, the likelihood of fraud in the form of malingering or symptom faking and exaggeration is readily reduced by savvy and well trained mental health providers and clinicians with expertise in the field of trauma treatment. In the case of first responders, it is usually the case that there is sufficient corroborative evidence and the presence of witnesses to either support or refute the existence of trauma exposure and the nature/intensity of exposure to catastrophic life experiences. Perhaps it is important to create a database with a list of trained professionals with expertise in this area throughout the State of Ohio.

In terms of expense, the greater probability is that the cost of not providing treatment will always be far greater than the actual costs of treatment with respect to lost revenue for sick leave, administrative leave, and unscheduled absences. There are also many first responders who are

able to remain on the job **because of treatment**. I would estimate that treatment for a period of 6-12 months may render the first responder able to maintain a higher degree of functionality on the job, with maintenance psychological interventions every 3-6 months for another year. Naturally, the course and frequency of treatment will always vary with the individual. It is my experience, with only a single exception, that treatment in close succession to trauma exposure and the onset of symptoms of PTSD increases the possibility that the first responder will be able to remain on the job while obtaining psychologically necessary treatment.

Thank you very much for allowing me to speak in support of SB 5 today.