The First Responder Resiliency Program (FRRP)

Program overview

The FRRP is a four-day (three night) residential program in British Columbia, Canada for police and fire-fighters. It is a professionally facilitated, group-based, evidence-informed model with an emphasis on skills that are deployable in real life situations.

The program brings eight first responders together at a time, along with two professional facilitators to helps them build skills for mental resilience. It aims "to strengthen their domestic, organisational, and operational stress competence and capacity".

Who do they recruit?

Since it began in 2017, 185 first responders have gone through the program in 23 cohorts. Leaders at any career stage can join, but the program prioritises leaders that have '*high social capital'* get priority[1]. This is because well respected and well networked leaders are seen to influence others in two respects. One, they confer legitimacy to the program and two, they set the standard that help-seeking is positive behaviour.

Program design

How

The program was shaped by findings from a literature review and qualitative interviews with thirty fire fighters and twenty-five police officers[2].

The curriculum (learning content) was co-designed and filled a gap. Namely, first responders in the co-design workshops identified there no existing programs that had an:

- an upstream and early intervention focus
- targeted a specific population
- used a delivery format that was culturally acceptable for agencies, and focused on mental health self-care and community capacity skills

Who

A collaboration of:

- Blueprint, UBC Faculty of Medicine
- The British Columbia Professional Firefighters Association (BCPFFA)
- British Columbia Police Association (BCPA)
- Vancouver Police Union (VPU)
- First responder participants (via co-design)

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[2] Interviews explored their experiences, sources of stress (operational and organisational) and sources of support.

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What

Core curriculum

Relies on education and experiential training to improve understandings of:

- the sources and effects of domestic, organisational, and operational stress and psychological trauma
- normalising service experiences
- understanding the physiology and neuroscience of acute stress response

and building skills in:

- self-regulation
- conflict management
- active listening (such as paraphrasing, reflecting empathically, and about the importance of advice-free listening)
- cognitive behavioural strategies
- strategic planning to amplify resources and practices for maintaining resiliency and well-being.

While the core curriculum is the same for all participants, group discussions allow for operational differences between firefighting and policing.

Learning Outcomes

The desired learning outcomes for the 34 hours of contact time per cohort are to provide participants with:

i. a better understanding of the mechanisms and effects of single incident or cumulative operational stress on the body, the brain, on behaviour, and on relationships
ii. an improved capacity to support their peers, and knowledge and skills to maintain personal resilience and wellbeing
iii. increased awareness of the impact of personal first response experiences on self and peers, the impact of gender on the experience of stress, and how it is interpreted and communicated with others
iv. a personal psychological wellbeing toolkit and strategic plan to maintain resiliency and well-being under operational load, and to identify and mitigate potentially overwhelming experiences in their roles through appropriate skills and resources
v. skills to improve relationships with peers, partners, and family members; and
vi. connection to services, supports and resources to better maintain their own resiliency and support their peers.

Theoretical framework and key terms

Programming was informed by:

- Cognitive Behavioural Therapy
- Exposure Therapy and Written Exposure Therapy
- Life Review
- Conflict Resolution and Communication Skills

- Motivational Interviewing
- Relaxation and Self-Regulation Training
- Mindfulness.

The *theory of change* is informed by:

- Cognitive Processing Theory
- Clinical Neuroscience
- Group Theory
- Gender Studies
- Seligman's Positive Psychology Model.

'*Resiliency*' was identified by participants as the preferred target of programming. The following working definition was used for this term:

"Resilience is a dynamic process in which psychological, social, environmental, and biological factors interact to enable an individual at any stage of life to develop, maintain, or regain their mental health despite exposure to adversity".[3]

Evaluation

Early outcomes data suggest the FRRP is safe, useful and has potential for scalability to other emergency response groups. Results support the continuation and gradual expansion of the program with ongoing evaluation.

Method

Data was collected and pooled from participants in the first seven programs (N=61). Questionnaires were given before and after the program, and then again at two weeks and at six months post program delivery.

The evaluation looked at program level impacts on individuals, including data to identify individuals requiring referral to additional supports, and to identify any unexpected or adverse outcomes.

Results

Change scores on all measures show clinically and statistically significant outcomes at six months post program, showing durability of results over time. This includes on standardized measures of depression (BDI-II), trauma symptomatology, (PCL-5) and social and occupational functioning and personal well-being (OQ45.2). There have been no negative comments or adverse outcomes noted for the participants to this date.

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[3] Key aspects of this definition is that resiliency is:

- Is both an individual and an emergent group capacity
- evolves over time
- is enhanced or eroded by internal and external factors (resources and demands)
- is best maintained by planning and regular practice (i.e., resilient individuals are "ready and resourced" versus "rugged").

In addition, participant feedback data (qualitative) was positive in nature. Testimonials can be found here and include:

- I arrived broken, anxious and feeling alone. I left empowered, more at peace, and with what I anticipate will be a lifelong bond with new peers that is unlike anything I have ever experienced.
- This program literally saved my life. Just 2 weeks prior I was seriously considering suicide - the third time of late, complete with a plan.
- I cannot say enough about this fantastic program, it has altered my life in a positive way.
- This wasn't about four days, this was about changing our lives This was the four most productive days of my 28 year fire-fighting career.
- For the first time I now know I am not alone and now I have some tools to deal with it
- I am no longer in a downward spiral of isolation and depression. I have a light at the end of the tunnel and am for the first time in a very long time hopeful for a bright future

Limitations

Initial evaluation results are based on a small pilot study and so need to be interpreted with some caution.

The current level of impact is likely related to the high level of commitment and engagement of participants. Their feedback may have been skewed in favour of a program they hoped would be continued so their peers could attend in the future. Future results are likely to be more modest so results must be interpreted with some caution.

Sustainability

- *Refresher courses* - To help consolidate learning, two (two-hour) virtual refresher courses are offered to participants three months after they complete the program.
- *Colleague referral* - To date, over ninety percent of participants have been referred by peers who had previously completed the program and recommended participation.
- *In demand* – there are standing waitlists for participation.

Lessons learned

This "resiliency" program turned out to not be a straightforward primary prevention effort. This is because after early pilot tests showed that over half of first responder participants arrived at the program with scores above clinical cut-offs on scales of depression and/or posttraumatic stress (BDI II and PCL-5), an element of reactive (i.e. tertiary) support was identified as necessary so that participants had support for early or existing mental ill health before starting the program.

This early learning was addressed by redesigning the program to ensure participants had contact with a mental health provider first, and one who understood the complex needs of emergency service workers.