# SHIFTING THE CULTURE FROM AVOIDANCE TO ADDRESSING POLICE SUICIDE


**Major Cities Chiefs Associates**
**Major County Sheriffs Associates**

**And**

**Federal Bureau of Investigation**
**National Executive Institute**
**Associates**

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# FOREWORD

**Timeline for the Study:**

During the November 2011 Major Cities Chiefs Association (MCCA) in Chicago, Illinois meetings, Dallas Police Department (DPD) Chief David Brown, asked if the Human Resources Committee (HRC) would look at police suicide for its annual project. MCCA President, Commissioner Chuck Ramsey, Philadelphia Police Department immediately said, that it was a good idea. HRC Executive Chairman, Chief Jim Cervera, Virginia Beach Police Department, said "Done. We have our marching orders." While the selection of this project was the easiest on record, the handling of suicides by police officers is difficult for individual employees and the agency as a whole. The sentiment was obvious around the table at the MCCA meeting – there should be something that chiefs could do to help prevent police suicides.

In our initial HRC meeting in Chicago, at our Quantico meeting, and in our final meeting on the 2012 project in Phoenix, the focus was on shifting the culture from an attitude of not addressing toward a concerted effort to prevent suicides. We determined in our research that there are several good and current studies on police suicide. We will cite some risks, stress factors, and related behaviors included in those studies, but our focus will be aimed at the chiefs' perspective. It is a top down, how to change the culture after recognizing these factors and behaviors, in order to prevent our officers from committing suicide. We point out that our agencies take measures to protect our officers from injury or from being killed. We do this through training tactics, body armor policy and procedures, and other means. We know that our chiefs believe suicide is no less tragic and that mitigation needs to be in place. A mitigation starting from the chief on down to the officer on the street, and intended to shift the law enforcement culture through training, policy, and procedures.

With this study we are going to recognize agencies that are doing well and provide tools to help change the culture from one avoiding the issue, to one addressing it. Our report will be presented to the MCCA in Dallas, Texas.

**Seminal and Ongoing Events:**

In February, 2012, Bud McKinney had a conversation with DPD Chief Brown in Las Vegas, Nevada. Chief Brown made the following comments and gave us permission to publish them in this study:

> I have served over 29 years in policing, and it seems we never talked about suicide. We had three officers commit suicide within an eighteen-month period. After the second officer suicide, there was an editorial piece in the local newspaper that mentioned the theory of the clustering of suicides. Then the third death. All

three of our officers were well liked. There was a whisper from employees that they knew something was wrong with each of the officers. The employees and I both wished that we knew how to help them. I decided that we needed to implement a formal plan. I repeat that none of these officers were problem employees, but all were well respected. There were two men who were sergeants and a female officer, all of them senior officers, and all were serving in patrol. I know that adversity strengthens us, but we had to accept that we needed help. I think to ask for help takes a lot of strength.

The day of the first suicide the officer's coworkers were concerned when he didn't come to work and we did what we call a welfare check. Everyone thought there was a problem, and when he was found dead, no one wanted to talk about it. I thought we needed to do something different and so I talked about it with my staff. I attended the funeral in full dress uniform and the command staff also attended. We began to change and decided that we were not going to be quiet about it. We started asking, why have we been quiet?

Six months later the second officer suicide involved a very popular female. Immediately it was thought to be a suicide. Again, the command staff attended the funeral. However, now our concern increased because of this serious problem. Even so, the funeral was well attended by DPD's employees. We continued working on the different programs that may be available, and we started discussing whether we should make counseling mandatory.

When the third officer committed suicide, everyone knew, and the organization was talking about it. We tried to analyze the situations. Again all were in patrol, on the street. Along with our analysis, we learned that another MCCA police department had five suicides in a similar timeframe.

The situation resulted in some of our employees saying they felt like they were helpless. We have 3,600 cops that we feel responsible for, and we wanted to help the employees find the courage to take action when they see our folks struggling. They needed to relate to those struggling, to have the commitment to get through to them, and to have them seek help. This is the twenty-first century, and we need to know when someone is suicidal. We now have a program being implemented.

**News reports Feb 14, 2012 by msnbc.com: 4th NYPD officer kills himself in 4 weeks**

> A 14-year veteran of the… Department apparently shot himself to death Monday after finishing his shift, becoming the fourth… officer to commit suicide in less than a month…The married father of three had texted his sergeant minutes before to tell him goodbye…
> Just eight days ago, another longtime officer…shot himself in his...home… The 20-year veteran was a father to 5-year-old twins.
> And last month, a 28-year-old officer killed himself while on duty after [he was told that someone had] called his precinct about the depression he was struggling with…
> Four days earlier…[another officer] shot himself in his parents' home…after getting into a car accident.
> http://usnews.msnbc.msn.com/_news/2012/02/14/10406675-report-4th-nypd-officer-in-4-weeks-kills-himself
> Retrieved 4/19/12

**From the Badge of Life Police Suicide Prevention Group website:**

> During the year 2010, reports the Badge of Life Police Suicide Prevention Group, there were 145 police suicides in the United States, a slight increase over 2009, during which there were 143. The suicide rate for police officers remains 17/100,000, compared to the general population's rate of 11/100,000. http://www.policesuicideprevention.com/id48.html
> Retrieved 4/19/12

To indicate a relevancy of this study, the results of our MCCA HRC Survey showed seven of the fifteen responding agencies reported experiencing fourteen officer suicides since January 1, 2009.

**Demographics of the Major Cities Chiefs Association/Major County Sheriffs Association/FBI National Executive Institute Associates Human Resources Committee:**

The Major Cities Chiefs Association (MCCA), the Major County Sheriffs Association (MCSA), and he FBI National Executive Institute Associates (FBI NEIA) are organizations consisting of Chief Executive Officers of the largest law enforcement organizations in North America and international law enforcement. Membership of the MCCA includes departments from the United States (US) and Canada. Members of the MCSA are from the US. While members of the FBI NEIA are worldwide. The Human Resources Committee (HRC) of the MCCA with members from the MCSA and the FBI NEIA meets three times a year to research, discuss, and formulate strategies for contemporary issues and incidences regarding personnel and organizational policy.

The HRC is comprised of individuals, both sworn and civilian professionals, who have distinguished themselves during their careers. They are charged by their CEOs with addressing law enforcement's challenges, and providing strategic alternatives for implementing, resolving, and mitigating human resource issues of today.

Readers of this work will realize how difficult it is for writers to state opinions or make suggestions that apply equally to local, state, urban, rural, suburban, or federal law enforcement agencies. However, the HRC's experienced and wise practitioners are not just espousing theory, but they actually transform these ideas into performance on a daily basis. These professionals created this written document from their research, experience, and many discussions within the HRC.

While the MCCA, the MCSA, and the FBI NEIA do not specifically endorse every conclusion or recommendation of this report, they use its information to generate discussion and reasonable debate during their roundtable sessions. The result is better informed CEOs who will continue to lead policy changes that will improve law enforcement services.

Companies or individuals identified or cited in this project are not endorsed by the MCCA, the MCSA, or FBI NEIA, and they are provided for information purposes only.

# SPECIAL DEDICATION

The Human Resources Committee (HRC) would like to honor one of its valuable leaders and productive members by dedicating this report to Administrator Patti Moore, Administrative Services Bureau, Phoenix Police Department, who is retiring.

Administrator Moore has served the Major Cities Chiefs Association (MCCA) on the HRC for 14 years since her assignment in 1998, by Chief Dennis Garrett of the Phoenix Police Department. While employed 18 years at Phoenix Police Department, every employee from chief to patrolman and all professional support have benefitted from Administrator Moore's leadership and personal touch in making sure employees were taken care of by Administrative Services. Administrator Moore helped establish Phoenix Police Department as one of the leading and cutting edge agencies, especially in human resources issues.

On our projects and through the HRC email network communication system, Administrator Moore's participation has greatly enhanced the success and professionalism of the committee collectively and of its individual members.

Administrator Moore has announced that she is retiring from the Phoenix Police Department this year, but has agreed to continue contributing some of her time and lending her experience to the committee.

The chiefs and the members of the HRC would like to personally thank Patti Moore for all of her hard work and dedication to the Committee. We appreciate her leadership and commitment to excellence. We also appreciate her friendship and wish her a happy and healthy retirement, and continued success in her endeavors.

# ACKNOWLEDGMENTS

The Human Resources Committee (HRC) of the Major Cities Chiefs Association (MCCA), the Major County Sheriffs Association (MCSA), and the FBI National Executive Institute Associates (FBI NEIA) would like to thank Unit Chief Skip Robb and Program Specialist Deborah Southard at the FBI Academy for providing accommodations and facilitating our January 2012, meeting at the FBI Academy. We also thank Phoenix Personnel Administrator Patti Moore for her generous hospitality during the 2012 spring meeting. Thank you to Chief Dave Rohrer, Assistant Chief Ed Roessler, Director Dwight Bower, and Administrative Assistant Kathryn Jeffries of the Fairfax County Police Department for their continuing dedication and support in facilitating, resourcing, and editing for the HRC.

Special thanks to the committee members who spent valuable time in research, discussion, writing, and editing of this report. The following list of HRC members contributed to the research and writing of this publication:

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This publication will be available online at the Major Cities Chiefs' website: www.majorcitieschiefs.org and the FBI National Executive Institute Associates website: www.neiassociates.org.

Chief Jim Cervera, Executive Chairman, MCCA/FBI NEIA HRC, and
Hugh M. (Bud) McKinney, Senior Advisor, MCCA/FBI NEIA HRC

## INTRODUCTION AND EXECUTIVE SUMMARY

*Courage is not the absence of fear, but rather the judgment that something else is more important than fear.* ~Ambrose Redmoon

"To serve and to protect…" is a broad mission statement, yet it clearly defines the specific expectations of a law enforcement officer. That mission statement is reflective of the commitment that sworn personnel exemplify in carrying out their duties to ensure that the citizens they serve are left in a better state than when they first encountered them. "To serve and to protect" is a simple statement, but a complex task that is embodied in the public trust of the citizens who believe that the law enforcement officers' response to their calls will leave them in a better state. The officers' commitment is further embodied in their training--basic and specialized training that prepares them to respond to those daily situations that range from routine and non--threatening to crisis and a state of emergency. It is that commitment that enables the law enforcement officer to respond while those personal matters in his or her life remain secondary to "serving and protecting."

Following the 2011, MCCA Conference in Chicago, it was evident that the matter of suicides among sworn officers was a concern by many law enforcement leaders and the number of executives who had experienced such a tragic event during their watch was more common than expected. The statistics are startling and the officers' reasons for committing suicide are often for the same reasons that the general population commits suicide. Unfortunately, the signs and indicators are often missed. The culture in the law enforcement community promotes a mindset that the officer must always be brave, mentally and physically strong and always in control. An appearance reflecting a lack of these traits is often seen as a sign of weakness—an unacceptable stigma in the police culture.

The goal of the MCCA Human Resources Committee (HRC) is to introduce this need to initiate a paradigm shift in the police culture. This shift mirrors the law enforcement agency embracing mental health wellness as strongly as it places emphasis on physical health and wellness. The long term goal achievement of this project would reflect the elimination of the stigma that is often associated with feeling isolated, hopeless and vulnerable because of a police culture that tends to discourage the law enforcement officer—the problem solver, from acknowledging their own issues and seeking ways to resolve them. While this particular report speaks specifically to sworn personnel, the valued services of the non-sworn men and women who represent our agencies daily as public safety professionals are of equal importance. Therefore, it is equally significant to note that the remedies and recommendations are applicable to all personnel—sworn and non-sworn.

This project of the MCCA HRC offers law enforcement leaders a practical and realistic approach to preventing suicide among law enforcement officers. It starts with understanding the police culture and how the socialization process actually begins with the recruit in training. Perhaps this is where the shift begins. As the training commences with the recruits, emphasis is placed on physical fitness, tactics, expectations of a first responder, understanding the law—motor vehicle law, juvenile law, arrests, searches and seizures and many other topics. Perhaps the training curriculum for the recruits should also include those subject matters that express the importance of sound mental health and wellness ranging from recognition and reporting to providing a list of available resources. Some law enforcement personnel are specially trained to respond to the mental health consumer. The training addresses the response, interaction and referral. The training is presented to the law enforcement officer with the assumption that he or she will provide this service to the citizen. However, the statistics show the mental health consumer and the officer in-need are sometimes the same person. Because of the inherent risks and stressors associated with the law enforcement profession; the increased rate of divorce; the increased rate of drug/alcohol use and the current economic conditions, law enforcement leaders must recognize the increased potential for the law enforcement officer to become the mental health consumer. The MCCA HRC noted that many law enforcement agencies offer some type of Employee Assistance Program. However, the greater question is, " How much time is allotted for training, educating and informing an agency's most vital resource (its personnel) on how and where to seek help should the need arise?" Too often, an agency is surprised by the suicide, when the signs (though sometimes subtle) were apparent.

To further encourage this paradigm shift, agencies would continue to raise the bar on promoting mental health and wellness beyond the training academies. The mental health and wellness component would become a part of in-service training and extend into the exit process for those who may be retiring, furloughed or even terminated from their service post.

Our MCCA HRC project evaluated both risk factors and behavioral indicators that commonly appear in the law enforcement profession. Rooted in depression and anxiety are PTSD, financial challenges, the need for greater family-work balance and alcohol and substance abuse. In recognizing this list of factors and indicators, the MCCA HRC sought the opportunity to offer resourceful information that would benefit the law enforcement profession. In an effort to identify those services, programs and resources utilized by the MCCA member agencies, a survey was conducted as a component of this project. With a small sampling of the responses, agencies have implemented an array of programs that support their personnel. These programs range from peer-based programs to EAP based programs supported by the greater governmental—

City/County/State entity. There is a diversity of the programs and services noted, many are discussed at length to also serve as a resource to the greater MCCA membership. There are also some innovative programs offered by non-profits that can be non-intrusive tools for our officers' use to help determine their fitness in handling physical, mental, and emotional stress. One such program being used by the Boston Police Department is the American Foundation for Suicide Prevention (AFSP). The AFSP instrument is called the Interactive Screen Program (ISP). ISP is an anonymous, web-based, interactive method of outreach to people with untreated depression and other mental disorders that put them at risk for suicide. See page 9 of this work for additional information about the ISP. In addition to the programs noted above, the survey indicated agency utilization of early warning systems, Critical Incident Response Teams, financial management programs, police psychologists, fitness for duty exams and training.

In noting the various aspects associated with officer-related suicides, the Committee found it necessary to note the legal considerations that impact the efforts an agency may take to address an officer's behavior and the potential liability it could face in the event a suicide occurs. Case law is presented with regard to Fitness for Duty and the American Disabilities Act and discipline. While the Committee recognizes that potential claims of recompense may be filed against an agency following an officer-related suicide, law enforcement leaders are encouraged to understand the possibility of this occurring and to seek further guidance from their respective legal advisors.

It is important for us to note that there a number of other studies that are available on police suicide including one in 2007, by the IACP titled *Preventing Law Enforcement Suicide: A Compilation of Resources and Best Practices*. Another completed by the FBI's Behavioral Science Unit in 1999, was a conference titled "Suicide and Law Enforcement." Finally, the IACP published an article in the May 2012, edition of the *Police Chief Magazine* titled "Law Enforcement Suicide: Current Knowledge and Future Directions." These and other studies provide additional tools for law enforcement agencies to use to build support programs and for education and training.

## THE POLICE CULTURE: A UNIQUE DYNAMIC

Bravery is not the absence of fear, but the mastery of it.
~John Berridge

While there are varying theories and descriptions of the police subculture, several characteristics and themes appear to be common. A socialization process takes place as new officers journey from ordinary citizen to sworn protector. Often, the result is a sense of isolation from the rest of society. A theme of solidarity forms as a means of coping with isolation. As behavior is controlled and inhibited by formal sources such as organizational structure, laws, and administrators, officers turn to the informal subculture for understanding and relief. Both, however, call strongly for conformity with existing guidelines. Officers learn that invisibility or "laying low" can further protect them from an increasingly critical world.

These themes may provide useful insight into the prevention of police suicides in two ways. First, some of these characteristics may add to the potential for police suicides. They may increase conflicts with others, enhance levels of stress, contribute to the deterioration of relationships, and produce feelings of isolation. Second, they may hinder or prevent the timely detection and reporting of cases where police officers may be susceptible to, or even contemplating suicide. This includes both cases of self-reporting and the reporting of others.

Although an understanding of police subculture may be helpful in preventing suicides, the goal is not to eliminate the subculture altogether. Though often viewed negatively, police subculture can have many positive effects (Scaramella, Cox, and McCamey, *The Police Culture*). Thus, a "paradigm shift," is proposed. Care must be exercised so that efforts do not lead to increased distance and isolation from affected officers and administrators.

### Socialization Process

The existence of subculture is not unique to law enforcement. Most organizations have some form of culture based on the organization's beliefs, values, and norms (Scaramella, Cox, and McCamey, *The Police Culture*). The transition from citizen to police officer has been described as one of abrupt change (Violanti). A socialization process begins as the transitional development occurs from recruit in the police academy to officer.[i] Police officers are socialized over time—from the beginning of the police academy, through field training, and by general exposure to the duties and roles of a law enforcement officer. These duties include interacting with the community, seeing the lesser qualities of life in society, and at times, the worst of humanity. Intertwined are other personal and professional stressors—family, finances, duty to citizenry, loyalty to the profession and comrades. Embodied in the socialization process is the relationship that is formed with co-workers through common interests. With the necessary training they receive, they learn the formal aspects of policing through

physical agility, academics, hands-on practical experience, and some aspect of testing to ensure training is retained. Once the academy is completed, the Field Training Officer (FTO) serves as a mentor in the field showing the rookie officer what "real police work" entails. For a designated period of time, the FTO is tasked with showing the rookie officer both formal and informal "ropes" of doing the job—day in, day out.[ii] Much time is spent between the two police officers in the patrol vehicle, on the beat and with other members who make up the criminal justice system—other officers, resource agencies, judicial officials, victims, and criminals. During this developmental transition, they are continuously learning the expectations of the organization and of the law enforcement profession while striving to meet the demands of the community. Dr. John Violanti references both Gilmartin and Turvey when he refers to this assimilation process that is an adaptation to the police role. While it occurs at both individual and social levels, it gradually dominates the officers' lives throughout their careers.[iii] This domination is further described by Dr. Kevin Gilmartin as a social dependency, or addiction to the police role. Attached to this adaptation are the emotions of excitement and depression. A strong assimilation can lack important skills needed to cope in difficult situations and impact or interfere with rational decision-making.[iv] As part of the socialization process, officers may find themselves in an exclusive clique. Their identities may not always be socially acceptable when they are not working. However, when police officers are off-duty, they cannot turn their emotions back on. They remain stuck in pre-described "tough guy" roles that are seen as necessary to be an effective police officer (Madamba, 1986).[v] Janowitz noted similarities between the police and the military, ". . . any profession which is continually preoccupied with the threat of danger requires a strong sense of solidarity if it is to operate effectively. Detailed regulation of the military style of life is expected to enhance group cohesion, professional loyalty, and maintain the martial spirit."[vi] In this circle, they may sometimes even find themselves talking about the job well after they have ended their duty. This closeness can sometimes create an alienation from others who are not law enforcement officers.

## Isolation

Early in their careers, police officers learn that they need to protect themselves from harm. Formal training emphasizes the creation of physical distance to protect oneself from attacks that may result in bodily harm. Since such threats may not be readily identifiable, officers are frequently taught to treat all non-police subjects with a level of suspicion and heightened awareness (Scaramella, Cox, McCamey). As an officer's career progresses, he or she soon learns that attacks can take other forms, such as public complaints, criticism, and unwanted scrutiny. Both physical and non-physical forms of harm create the need for officers to distance themselves from threat. William Westley (1970) viewed the police subculture as characterizing the public as hostile, not to be trusted, and potentially violent.

## Solidarity

Social isolation creates the need for police officers to strongly depend on each other. The evolution of this relationship enables such support and loyalty for each other

that it has the potential to be both positive and negative among comrades. It also has the potential to become an "us versus them" mindset. If allowed to develop negatively, this mindset can create suspicion and issues of distrust between rank-and-file as well as between officers and the public.

Trompetter, [vii] Blau, [viii] and Skolnick [ix] describe the solidarity as a form of inoculation or protection of an officer's psyche. This "inoculation" is believed to provide the foundation by which officers become impersonal or numb themselves to those potentially traumatic experiences in order to protect themselves psychologically (Trompetter 1984).[x] The similar experiences shared by the law enforcement officers reinforce the solidarity. Trompetter further argues that the solidarity of the squad room leads to the camaraderie of the badge, which comes before all else. However, this solidarity bolsters the officers' self-esteem and confidence, which enables the officers to deal with those day-to-day stressors of the profession. At the same time, it can destroy marriages, replace individuality, and foster addictive behaviors to include, but not limited to alcohol, drugs, and overall poor mental and physical well being.[xi]

**Invisibility**

Police officers often cope with their organizational environment by taking a "lay low" or "cover your ass" attitude. When they are recognized, it is usually for a mistake or violation rather than an achievement or effective policing (Scaramella, Cox, and McCamey). They learn early that drawing attention to oneself is more likely to result in negative rather than positive attention. Hard work entails the risk of exposure.

**Cultural Barriers to Detection and Reporting**

Components of the police subculture may make it difficult to detect early warning signs of distress. Even after warning signs have been identified, the existence of the subculture may inhibit seeking self-help or reporting others.

**Failure to Recognize the Effects of Culture**

Many officers, at least initially, fail to recognize the extent to which the subculture affects the way they view and act toward others (Scaramella). Champoux (2006) refers to veteran employees of an organization who are "not consciously aware of the basic assumptions" that guide the organization's behaviors.

**Bravery/Strength/Invulnerability**

Upon entry into the police world, new recruits are taught that the job requires bravery, strength, and a sense of invulnerability. Jean Larned (Understanding Police Suicide) describes the culture as "an atmosphere that prevents (recruits) from acknowledging issues that would make them appear weak or vulnerable." He adds that signs of perceived weakness are often hidden or not discussed for fear of losing the confidence and support of other officers. Similarly, Violanti (1996) describes the early stages of police training as attempting to "instill a sense of superhuman emotional

strength in officers." According to Clark and White, peace officers develop a strong sense of personal invulnerability and a "problem solver" mindset. These qualities can result in a lack of preparation, a sense of denial, and a delay in seeking professional help.

## Secrecy

Secrecy, often dubbed the "code of silence" or "blue wall of silence" is arguably the most well known component of police subculture. Superficially, it is defined in pop-culture as the unwritten rule of police officers "looking the other way" to protect other police officers. The concept, however, is far more complex. Because police officers often become socially isolated from the public and rely on each other for support and protection, they develop a strong sense of loyalty to other officers (Terrill, 2003). Crank (2004) defined it as a means for police officers to do their work without the interference of oversight. Neil Hibler (Police Suicides: Fatal Misunderstandings) refers to the law enforcement profession as involving "demanding work by prideful people," and those within it as "dedicated, ambitious, image conscious, professionals who do not easily reveal their doubts, struggles, or failings." Secrecy, then, applies to more than misconduct. It prevents an officer from revealing weakness or fear in oneself or in other police officers.

## The Paradigm Shift

According to Dr. Martin Hahn, Organizational/Industrial Sociologist, three features that determine a culture's strength can be identified. The first is thickness of culture, measured by the number of important shared assumptions. Thick cultures have many such assumptions. The second dimension is the extent of sharing. In strong cultures, layers and layers of beliefs are shared. Clarity of ordering is the third determinant of cultural strength. In some cultures, shared beliefs and values are clearly ordered, and their importance in relation to one another is known. Strength of culture is significant because strong cultures—in which the sharing of clearly ordered beliefs and values is pervasive—are more resistant to change than are weak cultures. The two factors that affect the strength of an organizational culture are: (1) the number of employees and (2) geographic dispersion. Small work forces and more localized operations contribute to the development of strong cultures because beliefs and values easily develop and become shared. [xii]

Law enforcement is a strong, thick culture with its shared assumptions and beliefs; both of which are clearly ordered. Because of its self-reliance and strong culture, these attributes of the profession can be detrimental as well by interfering with the officers' ability or willingness to seek assistance when dealing with mental health-related issues. We submit that a paradigm shift must take place in the law enforcement profession, in order to truly embrace the necessity for our front line personnel to recognize, seek, and obtain the professional assessment, treatment and mental health sustainment. This must extend beyond a periodic update of one's insurance plan during an open enrollment-benefits review/assessment period. Those aspects of policing that

are considered high liability often require significant training time with practical exercises included to ensure that the officers have a true grasp of its topical importance. With the growing increase of law-enforcement related suicides,[xiii] this enhanced exposure to mental health services would necessitate engaging the topic of suicide prevention for the entire law enforcement agency—from the agency executive to the lowest ranking staff member; whether sworn or civilian. Addressing mental health issues should occur at all stages of an employee's career to include the following:

- Before employment with a pre-employment screening.
- During employment via a wellness based mental health program.
- Beyond employment—furloughs, terminations, and retirements.

In this current economic season, individuals have been furloughed, dismissed, or retired from their posts while experiencing a sense of loss without knowing what resources are available, or how to reach out to the appropriate resources. Law enforcement officers have an elevated risk of divorce, alcoholism, and other emotional health problems.[xiv] Given professions like law enforcement whose culture is strong and where there is a potential stigma associated with seeking professional help, coupled with the personal distress one may be experiencing, this scenario can make for a difficult or nearly impossible effort to seek the much needed psychological help.[xv]

[i] Thomas, 9-11.
[ii] Ibid
[iii] Violanti, J. M., Ohara, A.F. & Tate, T.T., *On the Edge, Recent Perspectives on Police Suicide.* (Springfield, Illinois: Charles Thomas, 2011).
[iv] Gilmartin, K.M. (1986*)* Hypervigilance: A Learned Perceptual Set and it Consequences on Police Stress. In J.T. Reese & H.A. Goldstein (Eds.). *Psychological Services for Law Enforcement.* Washington, DC: US Government Printing Office.
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[vi] Skolnick, J., *Justice Without Trial: Law Enforcement in a Democratic Society.(* New York: John Wiley & Sons), 42-62.
[vii] Trompetter, P.S., *The Paradox of the Squad Room-Solitary Solidarity* (1984.) FBI (ed.), National Symposium on Psychological Services for Law Enforcement (pp. 533-535). Quantico, VA FBI.
[viii] Blau, T. H., *Psychological Services for Law Enforcement.* (New York: John Wiley & Sons, 1994).
[ix] Skolnick, J. H. (2004). A Sketch of the Police Officer's "Working Personality." In B.W. Hancock. & P.M. Sharp (eds.). Criminal Justice in America. (Upper Saddle River, NJ: Prentice Hall, 2004), 100-124.
[x] Trompetter, P.S. (1984 as cited in Thomas, 2011).
[xi] Thomas, 18.
[xii] Martin Hahn, articlesgratuits.com. 2007-04-21
[xiii] Bureau of Justice Statistics. (1990). *Preventing Law Enforcement Stress: The Organization's Role*. Washington, DC .
[xiv] Ibid
[xv] Hackett, D. P., & Voilanti, J. M., *Police Suicide.* (Springfield, Illinois: Charles Thomas, 2003), 16-36.

## INTERACTIVE SCREENING PROGRAM

Interactive Screening Program (ISP) is a web-based program that allows employees to anonymously participate in a stress and depression questionnaire and to receive feedback from a trained counselor within a 24-hour period. ISP is **not** a substitute for counseling, but rather an unobtrusive assessment tool for encouraging reluctant employees to pursue counseling, if appropriate. To participate, employees set up a user ID and email address of their choosing. The encrypted web-based format appeals to Generation Y employees who are more comfortable communicating via electronic means versus traditional telephone communication. Generating a user ID through the ISP website provides employees with an assurance of privacy and confidentiality.

Originally developed as a screening tool for university students, ISP may be adapted to any work setting. An independent study of this program concluded that 85% of university students who participated had serious depression or other suicide risk factors and 90% of these students were not seeking/receiving treatment. These findings support the premise that this program helps remove the stigma associated with seeking treatment. Currently, the Veteran's Administration and the Boston Police Department are considering implementation of the program. ISP is listed in the Suicide Prevention Resource Center/AFSP Best Practices Registry for Suicide Prevention.

Prior to implementation, agencies should consider the following:

- Involve the EAP coordinator in any discussions regarding implementation. The agency's existing EAP counselors will be expected to provide the staffing for the email responses, using a response template, and their buy-in is critical to the success of the program.
- Consider how the program will be announced to employees and give thought to including messages from both the executive level and also from peer counselors. Officers may be more receptive to the program if fellow officers in a peer counselor role promote it.
- Consider what additional questions should be included in the questionnaire. The questionnaire incorporates the PHQ9, an instrument commonly used by psychotherapists to measure depression, intense emotional states, drug/alcohol use, suicidal thoughts, etc., but may be customized to meet the specific needs/issues of the agency.

To learn more, visit the test site available at http://site2.isptestsites.com/welcome.cfm and contact Kimberly D. Gleason, Eastern Division Director, American Foundation for Suicide Prevention at 978-568-0818.

## SURVEY

An informal survey consisting of 12 questions was sent to the Major Cities Chiefs Human Resources Committee. See Appendix A for a copy of the survey questions. Fifteen law enforcement agencies responded to the survey and provided valuable information on various topics related to mental health programs and resources. Interestingly, seven of the responding agencies reported experiencing 14 officer suicides since January 1, 2009, an indication of the continued relevancy of this issue.

- All 15 agencies have contracted counseling services (Employee Assistance Programs). These programs included services for mental health, elder care, substance abuse, financial planning, and marital/family counseling services

- Thirteen agencies have a mechanism in place for both peer referrals for mental health issues and supervisor referrals for employees having issues.

- Six agencies have psychologists on staff.

- Twelve agencies have contracted psychologists.*

- Fourteen agencies have a Critical Incident Stress Management Team.

- Twelve agencies have a Peer Support Team.

- Three agencies had experienced three suicides since January 1, 2009, one agency had two suicides since January 1, 2009, and three agencies had one suicide since January 1, 2009.

- Ten agencies conducted recruit training in regards to police suicides, nine agencies provided first line supervisors with suicide training, six agencies provided top level management with suicide training and two agencies provided civilian support staff with suicide training.

*Note: some agencies have both on-staff and contractual psychologists to provide multiple avenues of treatment for officers.

Responding agencies indicated that the training provided is a combination of classroom, advanced officer/in service training, and roll call training. A variety of responses specified that training is provided periodically to new recruits, either yearly, every two years, on an on-going basis, or as needed. Lastly, the training

was developed and conducted through various practices by in-house staff, by outside consultants, or by in-house psychology staff.

We caution that the response rate for this survey is small and that our inferences in this report are not academically supported. However, we provide this summary as a means for gauging the strength of existing programs and addressing any gaps. For example, the fact that only 6 of the 15 agencies included the provision of suicide training to “top level management” seems to be an indication of a significant gap across multiple agencies.

## FINANCIAL STRESS AND THE NEED FOR FINANCIAL EDUCATION

Financial concerns significantly impact an individual's stress quotient. For someone who struggles with personal stress management, is reluctant to seek help, and/or is prone to depression, suicide may be considered as an escape from the burden of financial concerns. Obviously, everyone experiencing financial stress is certainly not a suicide risk. However, in these difficult economic times, financial stresses weigh heavily on employees and often impact employee engagement and productivity. Within the public sector realm, not only are employees impacted by budgetary constraints resulting in furloughs, layoffs, and reduced availability of overtime, training opportunities, and other resources, but also the traditional benefits afforded to public sector employees, such as defined benefit retirement plans and annual pay increases, have become targets of public scrutiny. For these reasons, we would like to suggest that leaders consider what can be done to promote financial education as a way to enhance overall wellness and workplace productivity. It will also help employees maximize the reach of their salary dollars.

In 2011, Boston College collaborated with MetLife to publish "The MetLife Study of Financial Wellness Across the Globe: A look at how multinational companies are helping employees better manage their personal finances."[i] This study compares pay and benefits programs in several countries and also emphasizes the need for financial education. Several findings of this study include the following:

- financial difficulties can have a negative effect on worker productivity.
- financial education can have a beneficial effect on employee wellness.
- significant changes to pension plans are occurring around the world.
- employees are ill-prepared to make good investment choices.[ii]

The MetLife study also references a 2011 article by WFD Consulting which attests that "financial stress was identified as a top work-life issue for both women and men across the countries studied."[iii]

Many studies have been conducted regarding the impact of financial stress on individuals. The 2004 study entitled, "The Consequences of Financial Stress for Individuals, Families and Society," by Christopher Davis, Ph.D., and Janet Mantler, Ph.D., of Carleton University offers a definition of financial stress as being "the subjective, unpleasant feeling that one is unable to meet financial demands, afford the necessities of life and have sufficient funds to make ends meet."[iv] Their work also indicates that financial stress is "associated with lowered self-esteem, an increasingly pessimistic outlook on life, and reduced mental health, particularly an increase in depression and hostility. There is also a link between financial stress and suicide and alcohol consumption, likely as a result

of the increased level of depression."[v] Physical health and marital relationships are also frequently impacted by financial stress.[vi] In their literature review, the authors reference a report to the US Congress Joint Economic Committee in 1984 made by M. H. Brenner in which he "projects that a 10% decline in per capita income would result in a 1% increase in total mortality, a 1.5% increase in cardiovascular-related mortality, a 3.7% increase in suicides, and a 2.6% increase in imprisonments."[vii] But, the authors identify that having a "strong sense of personal mastery" in terms of possessing problem solving and financial management skills and enjoying a strong relationship with a spouse or partner are the best defenses against financial stress.[viii] Employer-sponsored financial education programs are certainly an effective means of assisting employees in developing that "strong sense of personal mastery."

Financial literacy or savvy is a life skill that we assume employees possess upon joining our organizations. Most agencies provide financial counseling services through an Employee Assistance Program (EAP) and/or provide programs designed to assist employees as they prepare for retirement. Certainly advertisements for popular books written by financial sages are everywhere, like Susie Orman, Dave Ramsey, and others, but ensuring that employees synthesize this information and apply it in a practical and effective manner to meet individual needs is another matter altogether.

The Houston Police Department has developed a more extensive financial education program entitled, the "Circle of Life," using the expertise of one of its members who is also a certified financial planner. The Philadelphia Police Department includes a presentation on financial responsibility in their recruit academy (see Appendix 9). Members of the Virginia Beach Police Department may consult with the city's on-site representative from the deferred compensation program provider. This individual is available for private consultation and also teaches several courses available to all employees on themes such as budgeting, planning for retirement, managing investment choices, etc.

In 2010, the MCC HR Committee researched a paper on discipline trends among law enforcement agencies. At that time, many agencies were experiencing a surge of disciplinary actions related to alcohol/substance abuse and domestic violence. The Las Vegas Metropolitan Police Department recognized that officers' response to financial stress was directly related to this disciplinary trend. In the past few years, Nevada, a state founded on the principles of financial prospecting, experienced the highest rate of foreclosure in the nation. "Although the foreclosure rate fell in southern Nevada during 2010 by 7%, it remained at five times the national average with one in every nine households receiving at least one foreclosure filing during the year."[ix] In response to this crisis, the LVMPD developed a program available to employees and community members to provide information from a panel of experts to assist in connecting people to the resources they need and to ensure that individuals were not victimized by some of the fee-based services targeted at individuals

experiencing foreclosure. The Nevada Foreclosure Information Workbook was also made available at the workshop. Not only does foreclosure present a financial crisis for employees, but it also creates a community problem in that crime rates are also closely tied to rates of foreclosure (see the 2010 State Data Brief for a more detailed discussion). Creating a full day workshop to address this concern through financial education available to both employees and community members, provides important information to people in need, and enables them to make optimum choices for their situation.

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[i] The MetLife Study of Financial Wellness Across the Globe: A look at how multinational companies are helping employees better manage their personal finances Retrieved from the internet 4/4/12. http://www.metlife.com/assets/institutional/products/benefits-products/ml-global-financial-wellness-study.pdf

[ii] id. (p. 3).

[iii] WFD Consulting. (2011, May 18). New study shatters myth that work-life is a woman's issue. Retrieved from the internet 4/4/12. http://www.wfd.com/news/register-gms2011.html (p. 18)

[iv] The Consequences of Financial Stress for Individuals, Families and Society," by Christopher Davis, PhD and Janet Mantler, PhD. Retrieved from the internet 4/4/12. http://www.pfeef.org/research/efd/Consequences-Fin-Stress-for-Individuals-Families-and-Society.pdf (p.4)

[v] id. (p. v)

[vi] id. (p.. vi)

[vii] Brenner, M. H. (1973). Mental illness and the economy. Cambridge, MA: Harvard University Press, as cited in Davis and Mantler, 2004, (p.9)

[viii] The Consequences of Financial Stress for Individuals, Families and Society," by Christopher Davis, PhD and Janet Mantler, PhD. Retrieved from the internet 4/4/12. http://www.pfeef.org/research/efd/Consequences-Fin-Stress-for-Individuals-Families-and-Society.pdf (p. vii)

[ix] UNLV College of Urban Affairs, Center for the Anaylysis of Crime Statistics. State Data Brief. The Impact of Foreclosures on Neighborhood Crime in Nevada, 2006-09, December 2011Retrieved from the internet 4/4/12 http://cacs.unlv.edu/SDBs/Foreclosures/Foreclosures%20in%20Nevada%202006-09%20v4.pdf

## PEER SUPPORT

Some agencies have a peer support function that consists of sworn and non sworn personnel, specifically trained to offer emotional support to their co-workers in times of personal or professional difficulties. While peer support is not a replacement for professional psychological counseling services, it can be an effective tool when employee issues do not reach the level required for professional services or intervention. Peer support provides the opportunity to interact with other employees offering understanding and empathy from a similar position of background and experience.

The success of Peer Support is based on employee trust in their partners and co-workers. Because law enforcement officers are trained as problem solvers, they are often reluctant to seek assistance in times of emotional crisis. However, officers are more likely to share personal details of emotional conflict and crisis with their peers. Peer support contacts are informal and confidential unless the person in need of support discloses their involvement in criminal conduct or is determined to be a danger to self or others. The proper selection of team members is critically important to functionality and effectiveness. Approachable, diverse individuals, with excellent communication skills and an understanding of multicultural issues are highly desirable as Peer Support members.

Typically, training of peer support personnel can consist of the following:

- Development of active listening skills.
- Problem solving.
- Common peer support issues.
- Addictions.
- Suicide prevention.
- Medications.
- Self care.
- Ethical dilemmas.
- Recognition of depression, stress, anxiety, and PTSD.

## CIRT

Critical Incident Response Team (CIRT) personnel consist of specially trained, Law Enforcement personnel and can serve in a variety of capacities depending on their respective agencies needs and protocols. While these teams can be referred to by several different acronyms, such as CID, CIT, CISD, and others, one primary function remains the same: Critical Incident Debriefing. While there are some costs associated with maintaining a Critical Incident Response Team, the benefits of providing prompt information, emotional support and the opportunity to identify potential risk factors from peers far outweigh any costs.

A critical incident is a traumatic or stressful event that may involve psychological trauma. Examples of critical incidents include shootings, on-duty personal injuries, weapon take-aways, child deaths, serious injury accidents, homicides, and member suicides.

Law enforcement officers who are involved in any of the above listed events may develop symptoms associated with Post Traumatic Stress. Post Traumatic Stress is known to produce a normal reaction to an abnormal event. Although the reaction is considered "normal," it may bring about debilitating physical and/or emotional effects. Symptoms of Post Traumatic Stress can manifest immediately after a traumatic event or months later, where a connection to a traumatic event is unclear.

One UK study showed that 13% of suburban Law Enforcement officers suffer from Post Traumatic Stress. In an urban environment, the percentage may be higher. In general, law enforcement officers suffer from Post Traumatic Stress at a rate of two to four times higher than that of the public.[i]

CIRT members, working closely with EAP counselors or other mental health professionals, strive to mitigate trauma experienced by department members who have been involved in critical incidents/events. Upon notification of a critical incident, CIRT members promptly respond to diffuse the onset of any emotional issues experienced by the involved member(s). As part of the diffusion process, CIRT members evaluate and assess the need for additional, professional services and make appropriate referrals if needed. Response team members coordinate and facilitate a support debriefing for involved law enforcement members. This may also include dispatchers and chaplains.

During post incident stress debriefings, affected department members are educated on the normal psychological and physical responses to the traumatic incident/event that they have encountered. Additionally, department members are informed of problematic responses to traumatic stress and informed of healthy coping strategies for traumatic incident/event recovery. The debriefing process allows those members who have been involved in a traumatic incident

an opportunity to reflect on its impact. It is important to note that CIRT debriefings are separate from tactical debriefings and do not critique actions taken by personnel.

CIRT provides psychological first-aid to members involved in critical Incidents. Research has concluded that members who participate in critical incident stress debriefing within a 24-72 hour time period, after exposure to a traumatic event, experience fewer crisis related physical and emotional effects.[ii]

The training of CIRT personnel incorporates much of the same curriculum used for Peer Support. In fact, several law enforcement agencies use some of the same personnel that are used for peer support as members of their CIRT. However, CIRT members require a higher degree of training that also includes Critical Incident Stress Debriefing (CISD) protocols, increased assessment training, and increased guidance for Employee Assistance Program referral.

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[i] Post-traumatic stress disorder in UK police officers, p1, by Ben Green. Retrieved from the internet on 4/4/12. http://www.greenmedicolegal.com/PTSDPOLICE.pdf

[ii] Providing Critical Incident Stress Debriefing (CISD) to Individuals and Communities in Situational Crisis Joseph A. Davis, Ph.D., LL.D.(hon), B.C.E.T.S., F.A.A.E.T.S. Retrieved from the internet 4/4/12. http://www.aaets.org/article54.htm

## FIT FOR DUTY

The IACP defines a psychological fitness-for-duty evaluation as "a formal, specialized examination of an incumbent employee that results from (1) objective evidence that the employee may be unable to safely or effectively perform a defined job; and (2) a reasonable basis for believing that the cause may be attributable to a psychological condition or impairment." [i] Based upon the fact that a psychological fitness-for-duty evaluation may determine that an employee is unable to perform the essential functions of his/her position, it often conjures up negative thoughts and emotions.

Specifically in the law enforcement field, officers may be reluctant to complete a psychological fitness-for-duty evaluation for the fear of losing his/her position, being demoted, or having "their personal problems exposed for public ridicule." [ii] Similarly, Police Supervisors may be hesitant to request that an officer complete an evaluation due to their own fears of tarnishing the officer's career. However all parties involved should remember that "one of the functions of a fitness-for-duty evaluation is to make recommendations for education, retraining, counseling, or treatment" [iii] if warranted.

When identifying officers at potential risk for committing suicide, the psychological fitness-for-duty evaluation can be a useful tool if it is framed in a health maintenance context. For example, "if an officer is found psychologically unfit, some agencies ask the evaluator to provide mental health treatment recommendations that can help restore an officer to job fitness."[iv] The St. Louis Metropolitan Police Department's psychological fitness-for-duty program includes a mental health treatment component for officers found to be unfit for duty.

If an officer is referred for a psychological fitness-for-duty examination and the Department's psychologist determines that the officer is not mentally fit-for-duty, the officer will then be referred to the Department's contracted EAP provider for treatment. The treatment provided by the Department's EAP provider is confidential and no information regarding the officer's treatment plan is provided to the Department. The Department is only informed that the officer has or has not met the requirements of his/her treatment plan. Once the officer has satisfied the terms of his/her treatment plan, the officer is then referred back to the Department Psychologist for a follow-up exam. If the Department Psychologist determines that the officer is fit to return to duty, then the officer is returned to full duty. If the officer is not regarded as fit for duty then the Officer would be referred back to the Department's EAP provider for additional treatment.

As noted by Thomas E. Baker, M.S. and Jane P. Baker, M.S. in an article *Preventing Police Suicide*,

> …the research clearly indicates that being a police officer increases the risk of suicide. Appropriate intervention can occur during a

> specific time frame, but within the police culture, denial often delays assistance. Police officers throughout the ranks must stop pretending that the problem of police suicide does not exist or that it will go away. Someone must break the silence of denial and take action. With further research, innovative preventive programs, and proactive training, officers' lives can be saved. [v]

A psychological fitness-for-duty examination, while not new, can be one of the programs utilized to assess and treat suicidal tendencies.


Ayres, R. M. (1990). *Preventing law enforcement stress: The organization's role*. Washington, DC: Bureau of Justice Statistics.

Brent, D. A., & Bridge, J. (2003). Firearms availability and suicide: Evidence, interventions, and future directions. *American Behavioral Scientist, 46*(9), 1192-1210.


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[i] Fischler, Gary L., McElroy, Heather K., Miller, Laurence, Saxe-Clifford, Susan, Stewart, Casey O., and Zelig, Mark. *The Police Chief* Volume LXXVII, no. 8, August 2011. The Role of Psychological Fitness-for-Duty Evaluations in Law Enforcement.

[ii] Baker, Thomas E., M.S. and Jane P. Baker, M.S. *FBI Law Enforcement Bulletin*. October 1996. Preventing Police Suicide.

[iii] Miller, Laurence, PhD. The Psychological Fitness-For-Duty Evaluation: What Every Police Officer Should Know. Adapated from Practical Police Psychology: Stress Management and Crisis Interview for Law Enforcement.

[iv] Fischler, Gary L., McElroy, Heather K., Miller, Laurence, Saxe-Clifford, Susan, Stewart, Casey O., and Zelig, Mark. *The Police Chief* Volume LXXVII, no. 8, August 2011. The Role of Psychological Fitness-for-Duty Evaluations in Law Enforcement.

[v] Baker, Thomas E., M.S. and Jane P. Baker, M.S. *FBI Law Enforcement Bulletin*. October 1996. Preventing Police Suicide.

## TRAINING

Law enforcement personnel from the time they are hired until they retire are continually being trained. We train our personnel how to defend themselves, how to handle the problems of the public and how to work within the laws of the land and our own department's guidelines. The cumulative effect of these intense training and performance expectations can lead to a myriad of problems. How do we as an agency give suicide prevention training and awareness the same priority and attention as other training requirements?

Many agencies have suicide awareness training or Critical Incident Training (CIT) as part of their curriculum. These programs focus on the recognition and treatment options available to employees. In response to a survey* conducted by the Major Cities Chiefs Human Resources Committee in February 2012, 15 agencies reported training for police suicide prevention as follows:

- 66% of the agencies reported recruits receive training.
- 60% of the agencies reported first line supervisors receive training.
- 40% of the agencies reported top-level management receives training.
- 13% of the agencies reported civilian support staff receive training.

* It is noted that some agencies taking part in this survey did not provide a response to every question.

Training methods reported in the survey include classroom training, roll call training, and on-line training. Frequency of the training varied between agencies conducting classes periodically, annually, bi-annually, and on going as needed. Trainings were developed and conducted by some agencies with the assistance of outside consultants while others relied upon in-house staff. Most of the police suicide awareness training is focused on the recruits, officers, and first line supervisors.

Training should promote understanding/awareness of occupational risks, encourage healthy habits, and enable the identification of concerning behaviors in one's self and in others. In addition, there is a need to change the current culture in how we report and handle such incidents. "Seeking help for emotional issues can be misconstrued as a sign of weakness that can affect an officer's sense of self, as well as his or her relationship with peers."[i]

Training programs should go beyond the recognition of a problem and focus on how an employee intervenes, reports, and follows up for their benefit or for a fellow employee without stigma. "Our traditional suicide prevention and

peer support programs are focused on the officers who are in trouble. We ask, why are we waiting until they are in trouble to act?"[ii]

Training solutions should also include ways to minimize the stigma of asking for help for oneself or another.

> "Law Enforcement agencies can create an atmosphere in which officers are encouraged to seek help for their emotional concerns (and to encourage their peers to seek such help). Departments can educate their officers by making the analogy that seeking professional help for mental illness is much like seeking help for a physical illness. Expressing concern for a fellow officer's well-being can be compared to backing him or her up on the street."[iii]

Training programs that emphasize mental health awareness, stress management, coping skills, personal conflict resolution, and domestic or home relationship issues must be increased as part of an officers' on-going core requirements. The focus of training in safety must include emotional wellbeing along with personal safety. Training may be individualized for specific high-risk units or divisions such as sex crimes, child abuse, homicide, etc. This approach requires a holistic view that seeks to assist employees with emotional, physical, spiritual, familial, and social interactions.

In our effort to change the culture, every member of the agency should be mandated to attend training in this area. To reemphasize, this training should be presented to all, from the chief executive to the recruits. Civilian employees are also included in this mandate. Everyone needs to be educated about the problem and schooled on possible preventions and interventions. Any employee seeking help deserves support from a well-trained manager.

## TRAINING RESOURCES

The following resources are available for the purpose of designing a training program for a law enforcement agency:

**The Badge of Life** – www.badgeoflife.com
The Badge of Life is a group in the United States and Canada comprised of active and retired police officers, medical professionals, and surviving members from the families who suffered a suicide. The cornerstone of the Badge of Life program is called the "Emotional Self Care" program that focuses on voluntary annual mental health checkups.

**National P.O.L.I.C.E. Suicide Foundation** – www.psf.org
A retired police agent from Baltimore City Police founded this group. The foundation provides educational training seminars for emergency responders, primarily associated with law enforcement on the issue of police suicide.

**In Harm's Way: Law Enforcement Suicide Prevention**
http://policesuicide.spcollege.edu/indexIHW.htm This organization is a federally funded program that offers training seminars and workshops nationally on suicide prevention. This webpage offers a plethora of resources, reproducible materials, articles with varying viewpoints, statistics and opinions from which readers can form their own conclusions on the magnitude of the law enforcement suicide problem, its causes, and the best approaches to finding a solution.

**Suicide Prevention - A Guide for Supervisory Staff - Bureau of Justice Assistance U.S. Department of Justice**.
This resource is a guide for law enforcement supervisors outlining the risk factors, indicators, responsibilities, and things to do when confronted with a suicidal employee.

**A Leaders Guide to Suicide Prevention** –
www.in.ng.mil/.../SuicidePreventionLeadersGuideBrochure.pdf
This is a guide for Military Commanders, NCO's and supervisors outlining the risk factors, indicators, responsibilities, and things to do when confronted with a suicidal soldier.

**Emotional Survival for Law Enforcement** – Dr. Kevin Gilmartin, Ph.D., E-S Press
This is an introductory book for law enforcement officers on how to maintain a well-balanced life, including the topic of preserving one's family life after an adrenalin-filled shift. Gilmartin addresses the daily stresses of career fields like law enforcement with suggestions on how to leave the job behind and enjoy the activities you "usta" do in your life. He offers a variety of easy to implement suggestions, such as maintaining a planning calendar of family

activities, developing a good physical fitness program, and exercising control over unnecessary spending.

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[i] Gryphon Place Suicide Information for Law Enforcement Personnel retrieved from the internet 1/31/12 www.gryphon.org/dd_lawEnforcement.html.

[ii] A New Police Suicide Prevention Program for the 21st Century – EMOTIONAL SELF-CARE TRAINING retrieved from the internet 1/3112 www.policesuicidestudy.com/id5.html.

[iii] Gryphon Place Suicide Information for Law Enforcement Personnel retrieved from the internet 1/31/12 www.gryphon.org/dd_lawEnforcement.html.

## LEGAL CONSIDERATIONS

It is important to recognize that there are legal considerations that impact the efforts an agency takes to address an officer's behavior prior to suicide and the potential for liability after the suicide. The following discussion will focus on three areas of concern: psychological fitness for duty examinations, discipline, and the potential claims that arise after the suicide.

### Fitness for Duty Examinations (FFDE) and the Americans with Disabilities Act (ADA)

A police officer who commits suicide often will exhibit behavioral changes well in advance of the suicide that are noticed by coworkers and colleagues. These changes in behavior can result in increased citizen complaints against the officer. Coworkers may try to avoid working closely with the troubled officer. The officer's performance may decline. Supervisors may question whether the officer poses a safety risk to himself/herself or to others and whether the officer is psychologically and emotionally fit for duty. A psychological FFDE is usually in order when police administrators are concerned that an officer cannot safely and effectively perform the duties of a police officer.

Whenever an officer is ordered to undergo a fitness for duty evaluation, whether physical or psychological, the legal issues presented by the Americans with Disabilities Act (ADA) must be considered. The ADA prohibits discrimination in all employment practices against an applicant and employee who is considered to be a "qualified individual" with a disability. 42 USC § 12111(8). A "qualified individual" with a disability is someone who can perform the essential functions of the job with or without an accommodation. A disability is defined as a physical or mental impairment that substantially limits one or more major life activities. 42 UCS §12102(A).

When ordering an officer to submit to a FFDE, agencies should be aware that the evaluation may implicate the ADA. Specifically, the ADA provides that an employer:

> Shall not require a medical examination and shall not make inquiries of an employee as to whether such employee is an individual with a disability or as to the nature or severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity.

42 USC § 12112(d)(4)(A). Conversely, the ADA does not prohibit such exams when they are job-related and consistent with business necessity. 42 UCS § 12112(d)(4)(B). It is well-recognized that:

> Police departments place armed officers in positions where they can do tremendous harm if they act irrationally. The ADA does not, indeed cannot, require a police department to forgo a fitness for duty examination to wait until a perceived threat becomes real or questionable behavior results in injuries.[i]

On the other hand, courts caution that they are "keen to guard against the potential for abuse of such exams. [The ADA] prohibits employers from using medical exams as a pretext to harass employees or to fish for non work-related medical issues and the attendant 'unwanted exposure of the employee's disability and the stigma it may carry.'"[ii]

The business necessity standard required by the ADA may be met even before an officer's work performance declines if the agency is faced with significant evidence that could cause a reasonable person to question whether the officer is still capable of performing his job. For example, in *Brownfield v. City of Yakima*, 612 F.3d 1140 (9th Cir. 2010), a police officer was involved in several incidents in a short period of time that demonstrated a marked change in behavior:

- he was insubordinate in a meeting, using expletives to those in the meeting and leaving the meeting despite an order to stay, stating he was "consumed" with anger;[iii]
- he engaged in a disruptive argument with another officer during line-up, becoming so angry that he "wasn't really speaking full sentences;" [iv]
- the officer himself reported that he felt "himself losing control" during a traffic stop when a young child riding in the vehicle taunted him, causing him to become so upset that his legs were shaking;[v]
- the officer's estranged wife reported that he had struck her when she stopped to pick up their children;[vi] and
- the officer made several comments to a captain such as "It's not important anyway," "I'm not sure if it's worth it," and "It doesn't matter how this ends."[vii]

The officer was placed on administrative leave and ordered to undergo a fitness for duty examination. The officer was ultimately terminated for insubordination for refusing to undergo a final fitness for duty examination. In challenging his termination, he also claimed that fitness for duty examination he did undergo violated the ADA.

In upholding the district court's decision that the agency did not violate the ADA, the Ninth Circuit Court of Appeals agreed that the City of Yakima had an objective, legitimate basis to doubt Brownfield's ability to perform the duties of a police officer. In language that is apt for any analysis of whether a fitness for duty examination should be ordered, the court opined:

> Although a minor argument with a coworker or isolated instances of lost temper would likely fall short of establishing business necessity, [the officer's] repeated volatile responses are of a different character. Moreover, our consideration of the FFDE's legitimacy is heavily colored by the nature of [the police officer's] employment. ***Police officers are likely to encounter extremely stressful and dangerous situations during the course of their work. …When a police department has good reason to doubt an officer's ability to respond to these situations in an appropriate manner, an FFDE is consistent with the ADA.*** [viii] (Emphasis added)

Other cases involving police officers have likewise determined the ordered FFDE to be job-related and consistent with business necessity when the employee's mental and psychological health issues affected his/her job or the safety of the employee and/or the public. See, e.g. *Watson v. City of Miami Beach*, 177 F.3d 932, 935 (11th Cir. 1999)("In any case where a police department reasonably perceives an officer to be even mildly paranoid, hostile, or oppositional, a fitness for duty examination is job related and consistent with business necessity."); *Krocka v. City of Chicago*, 203 F.3d 507, 515 (7th Cir. 2000)(It was entirely reasonable and responsible for the Chicago police department to evaluate the police officer's fitness for duty once it learned that he was experiencing difficulties with his mental health).

**Disciplinary actions related to FFDEs and/or an officer's behavior**

Certainly, the issue of police suicide does not immediately conjure up the idea of discipline. Nevertheless, an agency must still be able to maintain consistent discipline even when an officer's behavior could signal a propensity for suicide. As indicated above, and in other sections of this paper, an agency can order officers and other employees to undergo a FFDE when there is substantive evidence that an officer is exhibiting emotional and psychological responses and behaviors that are incompatible with safe police practices.

Officers are trained that failure to follow a direct order constitutes insubordination that will result in discipline. When a FFDE is ordered, an officer should not be given the option to disobey that order just because he or she might be having some troubling psychological issues. A refusal to comply with an order to undergo a FFDE should be handled the same as any other refusal to obey a direct order. See e.g. *Theis v. City of Sturgeon Bay*, 2006 WL 2375518 (E.D. Wis.)(Police officer who exhibited a number of changes in his behavior was fired for insubordination after twice refusing to comply with

an order that he undergo a psychological evaluation to determine whether he was fit for duty.)

Likewise, imposing appropriate discipline when an officer's behavior violates police department policy is essential for the proper functioning of the police agency. The disciplinary process does not preclude efforts to get help for the officer through the EAP, peer support and other avenues of support. For instance, a police officer with the Salt Lake City Police Department had a history of both positive and negative performance during the course of her career.[ix] The negative aspects included two suicide attempts, and an ordered FFDE that revealed she had a substance abuse problem.[x] Her continued employment was conditioned on her participation in a monitored substance abuse program, continued sobriety, and she was warned that any similar future conduct would result in further disciplinary action, up to and including termination.[xi] One evening, the officer took numerous Ambien pills at her home, becoming extremely intoxicated. She contacted police dispatch several times, making lewd and offensive comments to the dispatchers. During one of her calls, she threatened to blow up the Public Safety Building.[xii]

As a result of this episode, the Chief of Police terminated the officer's employment. The officer challenged the termination by claiming that she had been treated more harshly than others who had attempted suicide by overdosing on prescription medication. [xiii] The court looked at the other cases and found that the officer had been treated similarly, even though the conduct for which she was ultimately terminated exceeded that of other officers. The court concluded:

> Fortunately for the citizens of Salt Lake, the Chief has not frequently had to deal with an officer who attempted suicide twice; was routinely late or absent and then lied about an absence on multiple occasions; was given multiple warnings; and ultimately misused the same prescription drug previously used to attempt suicide and then made bomb threats, engaged in sexual innuendo, and bothered police dispatchers. But this does not mean he cannot terminate someone for such conduct."[xiv]

When an officer's conduct cannot be corrected with progressive discipline and other support systems have failed, an agency often will have little choice left but to impose harsh discipline, including termination. These decisions should be made with the input of legal counsel and human resource professionals.

**Claims that may occur after a police officer's suicide**

The tragedy of an officer's suicide impacts the entire agency. Friends and coworkers question what they could have done to prevent the tragedy and agonize over what they failed to do. The family of an officer who commits suicide often seeks

recompense against the police agency and the city. These claims take two paths. One path is a 42 USC §1983 suit for violating the officer's substantive due process rights in failing to take adequate steps to prevent the officer's suicide. The second path is making a claim for compensation for a stress induced occupational suicide under workers' compensation law.

Families of officers who have committed suicide often claim that the police agency and the city failed to properly intervene to prevent the suicide by failing to address suicidal warning signs, by not requiring psychological counseling, by failing to take the officer's firearms away, and other similar contentions.[xv]

In order to maintain such a claim under 42 USC § 1983, the plaintiffs must show some constitutional right that was violated. In a claim for failing to prevent a suicide, or similar claims, the family often alleges that the agency and others deprived the deceased officer's right to substantive due process when they failed to take sufficient remedial action to prevent the officer's suicide. Courts have found, however, that the Due Process Clause of the Fourteenth Amendment does not mandate such an obligation.[xvi] See e.g. *DeShaney v. Winnebago County Dept. of Social Services*, 489 U.S. 189 (1989) (The Due Process Clause does not impose a duty on state officials to protect an individual against a risk of violence unless there is a "special relationship" between the state and the individual, such as the relationship when a state takes a person into custody); *Hanrahan v. City of Norwich*, 959 F.Supp. 118 (D.Conn. 1997)(where officer committed suicide with his service revolver while being questioned by a supervisor about a hit and run, father's §1983 claim failed because, even assuming that the department did not take suicide precautions as a matter of prudence, the Due Process Clause is not violated by simple negligence).

The surviving spouse of an officer who has committed suicide may seek redress under the state Workers' Compensation law. State Workers' Compensation laws, while similar, are not uniform so it is recommended that you consult with legal counsel to determine the potential outcome of a Workers' Compensation claim arising out of an officer's suicide in your jurisdiction. Some such claims brought under workers' compensation statutes for suicide have been successful, while most have failed.

In *Wilde v. Township of Cranford*, 2009 WL 1025193 (N.J.Super. A.D.), a widow of a police officer who committed suicide brought a claim under New Jersey's Worker's Compensation law. Her husband had a long career as a police officer, receiving many awards for professionalism and heroism. He was designated as the Incident Commander in 1999 when Hurricane Floyd struck.[xvii] He worked with little sleep during a fifty-one hour period. After returning home from the emergency incident, he appeared very tired and "seemed more wired" and "on edge". While talking to his wife that night, he reached for his service weapon and fatally shot himself in the head.[xviii] The Division

of Workers' Compensation found that there was sufficient proof that there was a direct causal connection between the officer's work and the "stress-induced occupational suicide" and awarded dependency benefits to the widow and her children.[xix] The town appealed and the New Jersey court upheld the award.

Other jurisdictions have determined that survivors of police officers who commit suicide are not entitled to benefits on the basis that the officer's suicide did not arise out of or in the course of his or her employment as a police officer. See, e.g. *Musa v. Nassau County Police Department*, 276 A.D.2d 851, 852 (N.Y.2000)(it is well settled that workers' compensation death benefits may be awarded for a suicide only where the suicide results from insanity, brain derangement, or a pattern of mental deterioration caused by a work-related injury); *Harvey v. Raleigh Police Department*, 384 S.E. 549 (N.C. App 1989)(the officer's employment as a law enforcement officer did not significantly contribute to, nor was a significant causal factor in, the development of the officer's depression which resulted in his committing suicide).

## Conclusion

Whenever issues arise that involve possible legal ramifications, agencies should seek the advice of legal counsel. The issues surrounding police suicide, particularly the agency response to conduct and behaviors that are exhibited prior to the final suicidal act, are no different.

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[i] *Watson v City of Miami Beach*, 177 F.3d 932, 935 (11th Cir. 1999).
[ii] *Brownfield v. City of Yakima*, 612 F.3d 1140, 1146 (9th Cir. 2010) quoting *EEOC v. Prevo's Family Mkt.*, Inc., 135 F.3d 1089, 1094 n.8 (6th Cir. 1998).
[iii] *Brownfield v. City of Yakima*, 612 F.3d 1140, 1143 (9th Cir. 2010).
[iv] *Id*.
[v] *Id.*
[vi] *Id.*
[vii] *Id.*
[viii] *Id*. at 1146-1147.
[ix] *Kelly v. Salt Lake City Civil Service Commission*, 8 P.3d 1048, 1051 (UT App 2000).
[x] *Id*.
[xi] *Id.*
[xii] *Id.* at 1050.
[xiii] *Id.* at 1056.
[xiv] *Id.* at 1057.
[xv] *Estate of Smith v. Town of West Hartford*, 186 F. Supp.2d. 146, 149 (D. Conn 2002).
[xvi] *Id*.
[xvii] *Wilde v. Township of Cranford*, 2009 WL 1025193 (N.J.Super.A.D.).
[xviii] *Id.*
[xix] *Id.*

## SUMMARY AND CONCLUSIONS

### WHAT IS AN ACCEPTABLE REASON FOR AN OFFICER TO DIE?

There is evidence that officers face more fatal danger from themselves than from criminals. By some estimates, the number of police suicides (300) is *two to three times* the number of line-of-duty deaths (100-150) in any given year. Recent trends have shown that police officers are dying less often in the line of duty, but more often by their own hands. It seems that a combination of factors is protecting officers from external dangers but leaving them increasingly unprotected from internal risks.

This increased risk comes despite some protective factors that police officers enjoy. In general, one protection against suicide is having a sense of purpose or meaning, knowing that one's efforts make a difference…that would seem to fit perfectly with the daily heroics of police officers. Support from a tight-knit community of colleagues also protects against suicide. Officers should also be protected by their own psychological makeup: Aamodt and Stalnaker (2001) described the "healthy-worker effect", in which the pre-employment selection process culls out some candidates via psychological and medical screenings, thereby creating a healthier population.

Why, then, does research consistently reveal higher rates of mental and physical illnesses among law enforcement personnel? It may be that the unique stressors and demands of police work outweigh the protective benefits. Shift work, struggles to maintain finances and relationships, and administrative demands all take tolls on an officer's psychological resources. Perhaps police are at higher risk for psychological injury because, despite the protections they enjoy, they are exposed to many more of the events that cause such injuries. Like physical damage, psychological injuries can result from one devastating crisis…or from the gradual, unrecognized accumulation of stress over time. Such cumulative trauma is the mental equivalent of a repetitive-motion injury and can be every bit as debilitating. Cumulative trauma may be uniquely difficult for lack of an obvious cause, a "smoking gun". The officer who cannot explain why he feels run-down or burned out may feel more isolated than an officer who is having understandable and "acceptable" reactions to a one-time traumatic event.

The core values of police culture – strength, stoicism, selflessness – may keep an officer from seeking assistance. Officers are, by training and culture, expected and encouraged to be strong and resistant to injury. On patrol, projecting strength and authority is not just important but vital. Equally important are a focus on others before oneself and the ability to present an unflappable "poker face" to the public. These abilities are necessary during a shift, and they are rightly valued. But what happens to

the officer who sustains a psychological injury? When an officer is trained and expected to be invulnerable, admitting "weakness" may seem unacceptable.

Cynicism and isolation, although useful in moderation, may also serve as barriers to calling for assistance. Officers are trained to have a healthy skepticism of what they are told, an attitude that often extends to the shifting dictates of command staff. They often become isolated, both by training and by experience. They often believe that others will not understand (or want to hear about) the more disturbing aspects of their work. Mistrust and isolation can become more entrenched when officers see people at their worst, at their least inhibited and most vulnerable. When an officer has limited trust and is used to solving problems himself, how can we expect him to blithely accept assurances that mental-health providers will honor his confidentiality or even be of value?

An officer's inner strength is a justifiable source of great pride, but that very pride becomes toxic when it discourages officers from freely acknowledging the escalating stress of the job. Shifting the culture to include the possibility of sustaining (and recovering from!) psychological injury may ameliorate the accumulated stress and exposure to trauma that is unavoidable in police work. If officers can be taught to prize resilience (the ability to *recover* from injury) as much as strength (*resistance* to injury), they may recover more quickly and seek assistance when appropriate.

The barriers to seeking assistance may begin to change when role models step forward to demonstrate good outcomes. From field training officers to shift supervisors to command staff, those who are willing to model the process of acknowledging a problem, seeking help, and recovering can have a profound impact on the officers who look to them for guidance. Commanders can also help by sending two clear messages: that it is "okay" to sustain psychological damage and to seek confidential assistance; and that they are confident that the officer will fully recover and resume his or her duties. The expectation of full recovery, communicated clearly to the patient, has long been a central principle of battlefield psychiatry and may apply equally well to modern law enforcement.

Education is another key component to increase awareness and decrease suicide rates. When officers and supervisors know the warning signs and have clear ways to address the problem, they are better equipped to resolve or prevent a crisis. Departments around the nation have instituted comprehensive education programs, often resulting in increased use of psychological services and decreased suicide rates.

This is a pivotal time for law enforcement, as police departments begin to examine the impact of their culture on officers. Research is lighting the way for the necessary changes to ensure officers' safety, not only from others, but from themselves.

More and more departments are developing suicide prevention programs that teach commanders, peers, and officers how to watch out for and support each other. As more officers become aware, and as more departments provide safe places for officers to seek assistance and recover, the law enforcement community will make significant strides in keeping its men and women safe. One loss of life is one too many.

## APPENDIX

This section contains some outstanding resources for use in building a "shifting the culture" process and for improving and implementing policy and procedures. Below are descriptions of each appendix.

Appendix 1 – MCC HRC Survey questions for informational statistics of our study.

Appendix 2 – Fairfax County powerpoint presentation entitled, Suicide: One is One Too Many.

Appendix 3 – Fairfax County email message to all employees proposed as a good model to use in informing an LE agency about an employee suicide.

Appendix 4 – Dr. Dave Corey's chapter on Principles of Fitness-for-Duty Evaluations for Police Psychologists from the *Handbook of Police Psychology*.

Appendix 5 – February 4, 2012, msnbc.com report "4th NYPD officer in 4 weeks kills himself."

Appendix 6 – April 22, 2012, The Republic report "More police officers seek counseling to combat trauma following major crime incidents."

Appendix 7 – *Monitoring Behavior to Assure Reliability for Law Enforcement Agencies* by the Psychological Services Group. Early warning signs, including emotional, behavioral, and physical indicators. Security issues and what to do.

Appendx 8 – "Police Suicide: Fatal Misunderstandings," by Dr. Neil Hibler. Injury to self-esteem and loss of control. Ending the struggle to regain control. Underestimating interventions. How to recognize officers who are failing. Enhancing efforts to reach out. Warning signs. Creating a work culture to promote engaging support. Programs that enhance teamwork, professional commitment, and reduce suicide.

Appendix 9 – Philadelphia Police Department's Recruit Personal Financial Planning: Management and Responsibility.

Appendix 10 – Trinity University's "Law Enforcement's Preferences for PTSD Treatment and Crisis Management Alternatives." Study suggests that LE departments should consider offering Evidence Based Treatments (EBT) to officers who develop PTSD.

# APPENDIX 1

Major Cities Chiefs Human Resources Committee
Survey
February 2012

Agency_____ Contact Name _____

Contact email_____

- Do you have an Employee Assistance Program (EAP)? (Contracted counseling services)

Yes_15____ No_____
If yes, which are the following services are provided:
Mental Health 15_____Financial Planning 10_____
Elder Care _14____Marital/Family 15_____
Substance Abuse 15_____

- Do you have a mechanism in place for peer referrals for mental health issues?

Yes__13___ No 2_____
If yes, is it effective?
Yes__11___ No___1__
If yes, please attach information regarding your program.

- Do you have a mechanism in place for supervisor referrals of employees who are having mental health issues?

Yes_13__ No__2__
If yes, is it effective?
Yes___12__ No_____
If yes, please attach information regarding your program.

- Do you have on staff psychologists?

Yes___6__ No____9_

- Do you have contracted psychologists?

Yes_12___ No 3____

- Do you have any of the following programs:

Critical Incident Stress Management Team (CISM) (i.e. CIT, CIRT) __14___
Peer Support__12___
If yes, are they effective?
Yes_14___ No_1____
If yes, please attach information regarding your program.

- Do you have any programs or initiatives in place to deal with officer suicides?

Yes__9__ No__5_
If yes, please attach detailed information.

- How many law enforcement officer suicides have occurred in your agency since January 1, 2009? ____0,0,3,1,3,0,1,3,0,2,0,1___

- Does your agency conduct training in regards to police suicides?

For recruits? __10___
For first line supervisors? __9___
For top level management? __6___
For civilian support staff? ___2__

- If yes, how is the training conducted? Please describe. (e.g.: classroom, roll calls, brochures)

5-classroom, advanced officer/in-service training, 3-all of the above, classroom and online, in service

- If yes, how often is the training provided? 2-periodically, 2-annually, 2-to new recruits, every 2 years, ongoing, as needed

- If yes, who develops and conducts the training? (e.g.: in-house, outside consultants or agencies or both)

6-both, Behavioral Science Unit does the training, 4-in house.

**Thank you for you assistance!**

**Please send your responses to Patti Moore at:**

**patti.moore@phoenix.gov.**

If you have any questions regarding this survey please contact Patti Moore, Phoenix Police Department, 602-262-6058, patti.moore@phoenix.gov.

**APPENDIX 2**

FCPD Police Psychologists
Jill Milloy, Ph.D. & Colby Mills, Ph.D.

# Suicide:
# One is One Too Many.

## Suicide Interviews—CHP

## Suicide is… (check all that apply):

- ❑ Selfish
- ❑ Despicable
- ❑ An escape
- ❑ Preventable
- ❑ A sign of weakness
- ❑ The coward's way out
- ❑ A permanent solution to a temporary problem
- ❑ A tragedy

## Police are at higher risk for suicide.

- By some estimates, twice the rate of civilians
- Immediate access to lethal means
- Higher rates of depression, substance abuse, and other risk factors for suicide
- Exposure to people at their worst
- Greater exposure to STRESS
- Specific risk factors for police:
  - Younger (ages 20-39—account for 55% of suicides)
  - Lower rank
  - Relationship problems

## Trauma and Suicide

- Police work means much more exposure to trauma
- PTSD (Post-Traumatic Stress Disorder) increases suicidal thinking by 2-3x
- If combined with alcohol…**10x!**
- Possible reasons:
  - PTSD sufferers feel out of control
  - PTSD sufferers feel weak
  - Police are trained to be strong & "bulletproof"
- Focus on *resilience* – the ability to heal quickly – not just strength

## It's not all bad news:

Protective factors include:

- ★ Resilience
- ★ Training & mental toughness
- ★ Support network
- ★ Sense of meaning & purpose
- ★ The "healthy-worker effect"

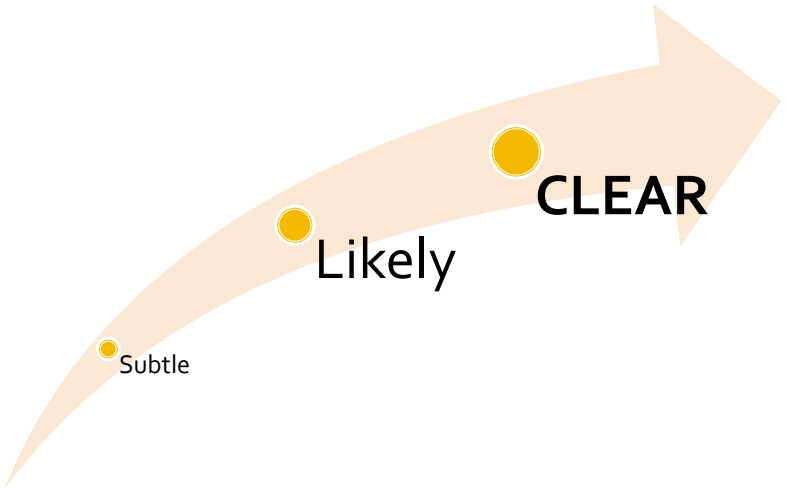
# What Causes Suicide?

- "Psychache": unbearable psychological pain
- **Loss**: of relationship
  of job or job status
  of money
  of "face"
  of CONTROL
- Hopelessness/helplessness
- Isolation
- "Tunnel vision", not seeing solutions to major life problems

# Myths About Suicide

1. *Talking about it might make the person do it*. Reality: Talking about it is OK for people who aren't suicidal; for people who <u>are</u>, it's often the best way to get relief & help.
2. *People don't talk about it if they're really going to do it*. This may be the most dangerous myth. 80% of completed suicides show warning signs first. Most people who attempt or complete talk about it within a week beforehand. If anyone mentions suicide, take it seriously. If they mention suicide and there are any other warning signs, GET THEM HELP.
3. *He'll be okay/He promised not to do it*. Thinking about suicide is a sign that someone probably won't be okay. It's a sign of desperation & pain—and even honest people will break promises when they're desperate and in pain.
4. *Suicidal people always want to die*. What they usually want is help —they are in pain and can't see other solutions. Is admitting pain a weakness…or a strength?

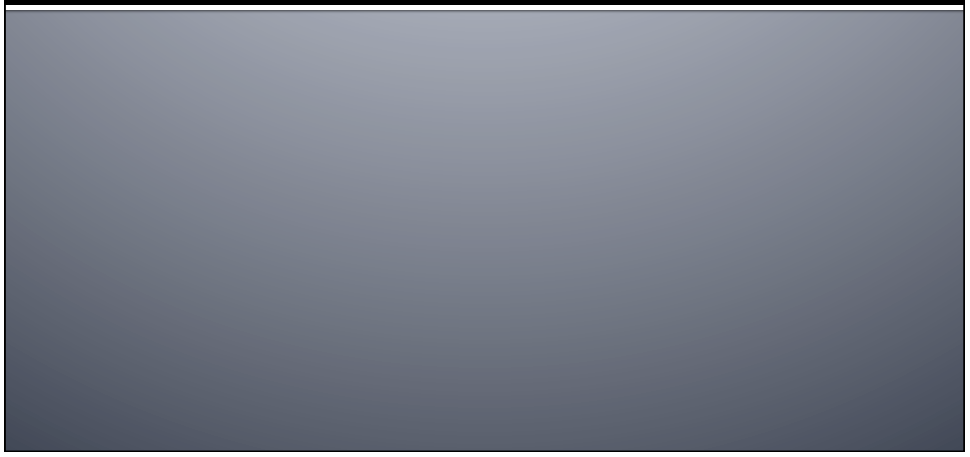
## Common Warning Signs




## Common Warning Signs (cont'd)

- Giving away belongings/saying goodbye
- Taking unnecessary risks
- Talking openly about suicide
- Comments/jokes/wishes about being dead
- "What's the point in living?"
- Self-isolation at work or at home
- Constant depression, especially **hopelessness**
- Suddenly "rebounding" from depression to happy or serene state
- Neglecting appearance, hygiene, uniform
- Poor job performance
- Poor sleep or appetite
- Self-harm

# WHAT TO DO:
# Responding to a Suicidal Officer



## "If you see something, say something."

- ASK ABOUT IT.
  - Objections: embarrassment, anger, "poking the bear", causing career problems, …?
  - How to bring it up:
    - Are you thinking about suicide?
    - How would you kill yourself?
    - What do you have with you? (weapons, pills, …)
    - I'm worried about you because you _____.
    - Let's go talk to someone together.
- Reach out to others
  - To get more *information*
  - To line up more *support*
- **DON'T LEAVE HIM/HER ALONE**

## Call for backup.

- When you're supporting someone who is suicidal, nobody expects you to do it alone. Would you go on a crisis scene without backup?
- Reach out:
  - To your PSYCHOLOGISTS (directly or via ISS Command)
  - Other Department resources—peers, Peer Support, chaplains

## AID LIFE

- **A**SK
- **I**ntervene immediately
- **D**on't keep it a secret

- **L**ocate help
- **I**nvolve Command
- **F**ind someone to stay with the person
- **E**xpedite

## "What Do I Say?"

- No consequences
  - Feeling suicidal or seeking help will NOT result in disciplinary action (but certain behaviors might)
  - *Benevolent* stance of Department
  - Officer needs to hear this from Command
- Confidentiality
  - Psychologists/ISS respect officer's privacy (exception: immediate risk)
  - Reassure them that YOU (the supervisor) will respect their privacy, too
- HOPE
  - "You can make it through this"
  - Department has resources, people who can help
  - In most cases, **officers return to full duty**

## If Suicide is Imminent (CRISIS)

- Activate the psychologists (via ISS Command or directly)
- Get the person away from lethal means—gun, pills, CAR, …
  - Hold the gun/pills yourself—**not** 3rd party
- If he/she agrees to go get help, have someone else drive while you sit in the back with the person and keep talking
- Stay focused on getting through it, one moment at a time
- Backup is even more important
- What would you do if this was a citizen??

# Suicide Prevention.

## Multiple Levels to Intervene

- YOUR OFFICERS
  - Know your officers, "know the baseline" so you can spot differences
  - If you catch warning signs, intervene
- POLICE CULTURE
  - Give people permission to talk about it—lead by example
  - Focus on resilience as well as strength
  - Point out good performance
- THE DEPARTMENT
  - Department-wide education/suicide prevention programs decrease suicide rates

## Do's and Don'ts for Supervisors

- DO know your officers
- DO reduce stigma:
  - Police work = cumulative stress & pressure
  - It is OK and expected to have strong reactions to abnormal or traumatic events…and then bounce back.
  - What messages are you sending? Words, behavior
- DON'T ignore warning signs
- DON'T intervene alone (get backup)

## What the Department is Doing to Help Prevent Suicide

- Promoting Wellness
  - Resilience
  - Stress management
  - "Mental fitness"
- Suicide Prevention
  - Developing Department-wide education program
- More psychologist coverage

# If a cat can save a life…?

**Police Suicide Prevention and Awareness**
by Kevin Caruso (http://www.suicide.org/police-suicide-prevention-and-awareness.html)

The police officer took his unloaded gun, placed it in his mouth, and pulled the trigger -- he needed to see if he could actually pull the trigger after pointing the gun at his own head.
He was preparing to die.
He only needed one practice attempt; now he felt he was ready.
He then slowly loaded his handgun and began raising it to his head.
But the door to his room was opened, and before he could pull the trigger, his cat walked in.
He paused, looked at the cat, put the gun down and said to himself, "Who will take care of my cat if I kill myself?"
Seconds away from a suicide, this officer decided not to die.
And yes, this is a true story. The officer received help and is doing fine now, but wants to remain anonymous.

If a cat can prevent suicide, think of how much impact you can have.

# THANK YOU!

- This is a collaboration—we're working together to keep officers safe
- Suicide assessment is not your responsibility—but suicide *prevention* is everybody's job
- Remember to take care of yourselves too—lead by example

# Sources of Information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- O'Hara, A.F. & Violanti, J.M. (2009). Police suicide: a comprehensive study of 2008 national data. *Journal of Emergency Mental Health*, 11:1: 17-23.
- Shneidman, E. (1998). The Suicidal Mind.


# For Backup in a Crisis

- Colby Mills, Ph.D.: tel # (XXX) XXX-XXXX
- Jill Milloy, Ph.D.: tel # (XXX) XXX-XXXX
- Lt. Andy Hill: tel # (XXX) XXX-XXXX
- Lt. Chris Marsh: tel # (XXX) XXX-XXXX
- Major Sharon Smith: tel # (XXX) XXX-XXXX
- Bob Fitzpatrick, Director Personnel Resources Division: tel # (XXX) XXX-XXXX
- Chaplains—through each station

# APPENDIX 3

Announcements

# ***Message from the Chief of Police*** has been added

Modify my alert settings | View Message from the Chief of Police | View Immediate Awareness | Mobile View

| | |
|---|---|
| **Title:** | Message from the Chief of Police |
| **Body:** | As some are already aware, we are investigating a tragic case involving former police officer and sergeant John Doe and his daughter that occurred last night. As many know, John was also the brother of Second Lieutenant Robert Doe.<br><br>The investigation is ongoing, but, with profound sadness, I ask that all join me in keeping John and his daughter, their family, and his brother, 2Lt. Doe, in your thoughts during this difficult time. We are supporting the family as best we can, and will continue to do so. But our concern is also with all who knew and worked with John or responded to the scene, or are involved in the investigation. An incident such as this can impact each of us not only as police officers and detectives, but as friends and peers and, for many of us, as parents.<br><br>As police officers in particular we can too often hide our emotions and feelings, when often it is better to share them with someone or seek support, or just "talk" with someone. Peer support, chaplains, and our psychologists are available and I strongly encourage anyone who wishes to speak with someone to please do so without hesitation. We are proactively planning visits to some locations where John worked, but others may speak with a peer support member at their station or division, or reach out to Major Sharon Smith, Lt. Chris Marsh, or Lt. Andy Hill to request peer support. Similarly, we can readily facilitate any other support anyone may desire.<br><br>With sympathy and respect,<br><br>Colonel Dave Rohrer<br>Chief of Police |
| **Expires:** | 4/6/2012 11:59 PM |
| **Point of Contact:** | Colonel David M. Rohrer |

Last Modified 3/27/2012 11:31 AM by Rohrer, Dave

***Please note that Colonel Rohrer's original text has been edited to the extent of substituting "Doe" for the family surname.***

## APPENDIX 4

# HANDBOOK OF POLICE PSYCHOLOGY

Edited by

Jack Kitaeff

Private Practice of Police Psychology
Arlington, Virginia

Routledge
Taylor & Francis Group
New York London

Routledge
Taylor & Francis Group
270 Madison Avenue
New York, NY 10016

Routledge
Taylor & Francis Group
27 Church Road
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# Contents

## PART V Clinical Practice



## PART VI Treatment and Dysfunction

# 13 Principles of Fitness-for-Duty Evaluations for Police Psychologists

*David M. Corey*

## INTRODUCTION

Police employers have a legal duty to ensure that police officers under their command are mentally and emotionally fit to perform their duties, and failure to do so can result in significant civil liability (*Bonsignore v. City of New York,* 1982) and serious consequences to citizens, the examinee, other officers, an employing agency's reputation, and trust in the community (Corey, 1988). Various courts have interpreted this duty to include the authority to mandate psychological fitness-for-duty (FFD) evaluations* of police officers reasonably believed to be impaired in their ability to perform their job functions because of a known or suspected psychological condition (*Colon v. City of Newark,* 2006; *Conte v. Horcher,* 1977; *Deen v. Darosa,* 2005; *Kraft v. Police Commissioner of Boston,* 1994; *McKnight v. Monroe Co. Sheriff's Dept.,* 2002; *Tingler v. City of Tampa,* 1981; *Watson v. City of Miami Beach,* 1999).

The circumstances giving rise to FFD evaluations of police officers are many and varied. They may involve suspicion of job-relevant psychopathology associated with on-duty performance (e.g., excessive force, repeated problems of judgment), off-duty conduct (e.g., domestic violence, driving while intoxicated), a suicide attempt, psychiatric hospitalization, or a disability claim. Stone (2000) reported that 26% of the cases from his own practice in the southern region of the United States resulted from suspected psychopathology (i.e., diagnosable mental condition), 19% from excessive force issues, 15% from substance abuse, 13% from behavior implicating poor judgment, and 9% from domestic violence.

Dawkins, Griffin, and Dawkins (2006) utilized an alternative classification scheme for their analysis of the FFD referrals in their own Midwestern practice. Similar to Stone, they found that 16.5% of the more than 200 referrals they analyzed involved alcohol use, but they reported more than twice as many referrals involving domestic violence (20.5%). They reported that 16.3% involved other behavioral concerns, 36.9% pertained to psychopathology or emotional distress, and 4.7% were for officers being considered for rehire following employment separation.

The right of a police employer to intrude on the medical and personal privacy of its officers derives from two special features of police work: the power of the position and the fact that police officers are public employees. Police officers are members of quasi-military organizations, "called upon for duty at all times, armed at almost all times, and exercising the most awesome and dangerous power that a democratic state possesses with respect to its residents—the power to use lawful force to arrest and detain them" (*Policemen's Benevolent Association of New Jersey v. Township of Washington,* 1988, at 141). As citizens, police officers retain their constitutional rights (e.g., *Garrity v. New Jersey,* 1967), but as public employees, they "subordinate their right to privacy as a private

* The term *FFD evaluation* is used throughout this chapter to avoid the more awkward abbreviation *FFDEs* in its plural form. Some authors and publications use the latter abbreviation, and they are used here when quoting from them. These terms and abbreviations are equivalent in meaning.

citizen to the superior right of the public to an efficient and credible police department" (*Richardson v. City of Pasadena,* 1973/1974, at headnote 1). In the words of the U.S. Supreme Court, "the public should not bear the risk that employees who may suffer from impaired perception and judgment will be [in] positions where they may need to employ deadly force" (*National Treasury Employees Union v. Von Raab,* 1989, at 671).

The employer's duty to ensure a psychologically fit workforce does not, however, extend an unfettered right to require such evaluations of any police officer in any instance (*Denhof et al. v. City of Grand Rapids,* 2005; *Holst v. Veterans Affairs,* 2007; *Jackson v. Lake County,* 2003; *McGreal v. Ostrov,* 2004). Instead, the employer's duty is balanced by public interests and the employee's constitutional, civil, and property rights and interests.

This chapter will explain how FFD examinations, and the findings and opinions that result from them, are shaped and restrained by six overarching considerations:

1. The threshold for determining when an employer may properly require an officer to submit to an FFD evaluation
2. The definition of unfitness
3. The nature of the examiner's role and relationship to the various parties
4. The scope of the examination and the sources of information relied upon
5. The limitations on disclosure of private information to the employer
6. The examinee's statutory procedural rights

Each of these considerations will be discussed in this chapter in the context of 15 proposed principles for conducting FFD evaluations of police officers organized under four topics: referral issues (Principles 1–7), examination and procedural issues (Principles 8–11), determining fitness (Principle 12), and communicating the results (Principles 13–15).

## PRINCIPLES OF FITNESS-FOR-DUTY EVALUATIONS

Several excellent texts exist on the topic of FFD evaluations of police officers (e.g., Decker, 2006; Rostow & Davis, 2004; Stone, 2000), but these are aimed at a mixed audience of police employers and examiners. This chapter is focused solely on the practical and conceptual requirements of FFD evaluations for police psychologists, beginning with the initial referral and progressing to the examination procedures, formulating an opinion or determination of fitness, and communicating the results.

In his seminal book, *Principles of Forensic Mental Health Assessment,* Heilbrun (2001), as well as Heilbrun, Grisso, and Goldstein (2009), presented a series of established and emerging principles for conducting psychological evaluations for the courts. I have drawn from this framework to present 15 principles of FFD evaluations for police psychologists derived from the professional literature, case law, federal statutes and regulations, practice guidelines, ethical standards, and my own experience conducting more than 1,000 fitness examinations.

### Referral Issues

#### Principle 1: Assess how the employer met the legal threshold for mandating a fitness examination

By law, an employer may require an FFD evaluation of an incumbent police officer only when objective facts pose a reasonable basis for concern about his or her fitness (Equal Employment Opportunity Commission [EEOC], 1997; McDonald, Kulick, & Creighton, 1995). This is a central distinction between FFD evaluations and pre-employment psychological evaluations of police applicants. Under the Americans with Disabilities Act of 1990, when employers require applicants to undergo pre-employment psychological screening, the evaluation must be given to all entering

applicants in that job class. In addition, to the extent that the psychological evaluation constitutes a "disability-related question" (i.e., one or more questions likely to elicit information about a disability; see EEOC, 1995, p. 3) or "medical examination" (e.g., a procedure or test that seeks information about an individual's physical or mental impairments or health; see EEOC, 1995, p. 11), it may be administered only after the employer has given the applicant a conditional offer of employment (29 C.F.R. §1630.14(c); see also *Leonel v. American Airlines,* 2005).

In contrast, when making a disability inquiry or medical examination of an *incumbent employee,* the ADA requires the employer to meet a fact-specific, individualized threshold; namely, that the questions or examination are "job-related and consistent with business necessity" (42 U.S.C. §12112(d)(4)(A); 29 C.F.R. §1630.14(c)). In general, the ADA regards this threshold as having been met when an employer "has a reasonable belief, based on objective evidence, that (1) an employee's ability to perform essential job functions will be impaired by a medical condition, or (2) an employee will pose a direct threat due to a medical condition" (EEOC, 2000, Question 5, p. 7). In other words, legal justification for a compulsory mental health examination of an employee requires objective evidence of job-related performance problems or safety threats *and* a known or reasonably suspected mental condition. As Gold and Shuman (2009) point out, "One of these in the absence of the other represents an insufficient basis for an FFD" evaluation (p. 244). These threshold conditions also are reflected in the "Psychological Fitness-for-Duty Evaluation Guidelines" published by the International Association of Chiefs of Police (IACP, 2009). (Note: The IACP Guidelines are written and ratified by the members of the IACP Police Psychological Services Section, represent best practices of police psychologists who perform these examinations at the request of police employers, and "should guide the expectations of examiners, examinees, and agencies" [Borum, Super, & Rand, 2003, p. 142].)

Sometimes this threshold may be met when an employer knows about an employee's medical condition, has observed performance problems, and reasonably can attribute the problems to the medical condition. An employer also may be given reliable information by a credible third party that an employee has a medical condition, or the employer may observe symptoms indicating that an employee may have a medical condition that will impair his or her ability to perform essential job functions or will pose a direct threat. Although health problems that have had "a substantial and injurious impact on an employee's job performance" (*Yin v. California*, 1996, at 868) can justify an FFD evaluation, these are not the only circumstances that satisfy the business necessity standard.

Several courts have held that an employer may preemptively require an FFD examination without showing that an employee's job performance has suffered as a result of health problems, "particularly when the employer is engaged in dangerous work" (*Brownfield v. City of Yakima*, 2010, slip op. at 10825; see also *Cody v. CIGNA Healthcare of St. Louis, Inc.*, 1998; *Watson v. City of Miami Beach*, 1999). Although the business necessity standard "is quite high, and is not to be confused with mere expediency" (*Cripe v. City of San Jose*, 2001, at 890), this objective test may be met without either known medical problems or observed deterioration in the performance of essential job functions. In *Brownfield*, the court concluded that an officer's repeated volatile responses to coworkers and supervisors established business necessity for a series of fitness evaluations. Moreover, the court noted,

> our consideration of the FFDEs' legitimacy is heavily colored by the nature of Brownfield's employment. Police officers are likely to encounter extremely stressful and dangerous situations during the course of their work. When a police department has good reason to doubt an officer's ability to respond to these situations in an appropriate manner, an FFDE is consistent with the ADA. (slip op. at 10827)

This threshold analysis is a critically important one for the employer, but it is equally crucial for the examining psychologist who wants to avoid becoming the target of litigation where the employee has successfully shown that a disability-related inquiry or medical examination was not job related and consistent with business necessity (*Denhof et al. v. City of Grand*

*Rapids,* 2005). Indeed, Borum et al. (2003) regard this as "[t]he most fundamental legal issue in FFDEs" (p. 140).

IACP guidelines recommend that the employer and examiner "consult before an FFDE commences in order to ensure that an FFDE is indicated in a particular case" (IACP, 2009, Guideline 4.3). An employer's initial consultation with the examiner may provide important evidence at trial, buttressing its belief that a mental health condition prevented the employee from performing an essential function of the job (*Sullivan v. River Valley School District,* 1999).

As important as the threshold analysis is for managing litigation risk, it also serves two other valuable purposes. First, it provides an opportunity for the examiner to discuss with the employer less intrusive, nonmedical alternatives (IACP, 2009, Guideline 4.2), given that "[t]he stakes involved in an FFD evaluation for both employees and employers cannot be overstated" (Gold & Shuman, 2009, p. 238). Courts also cite the intrusive characteristics of an FFD evaluation, along with the potential adverse impact of disclosure of information gathered in the examination, when considering whether an evaluation was lawfully ordered (*Hill v. Winona,* 1990; *Stewart v. Pearce,* 1973). Thus, prereferral consultation between the employer and examiner helps to ensure that other appropriate alternatives are considered before mandating the FFD examination. As Rostow and Davis (2004) note, "In the end, the most appropriate referrals should be work related and reasonably connected to a suspicion of mental or emotional illness" (p. 149).

When a referral involves job relevant behavior reasonably linked to a possible mental health condition, this means only that the employer *may* order an FFD evaluation, but nothing in the ADA compels it. Indeed, an array of cases illustrate the appropriateness of an employer's decision to terminate an employee known to have, or reasonably suspected to have, a mental disorder when the employee's conduct, or behavioral manifestation of the disorder, was such that it rendered him or her unqualified for the position (e.g., *Marino v. U.S. Postal Service et al.,* 1994; *Mazzarella v. U.S. Postal Service,* 1994; *Palmer v. Circuit Court of Cook County,* 1997). In general, when an employer knows in advance that it would be unwilling to return an employee to the job in the event that the employee is found fit for duty, alternatives to an FFD examination should be considered. Thus, in a prereferral conference involving cases of gross misconduct, examiners may wish to discuss with the employer the option of considering termination in lieu of an FFD examination. Employers may benefit from being reminded that the ADA generally does not require an employer to tolerate violations of workplace rules and policies, including those that prohibit workplace violence or threats of it, or to retain employees who engage in such violations. Whereas police employers are permitted to mandate FFD evaluations under the conditions discussed above, they are not required to do so as an alternative or precursor to termination. On the other hand, they also may not take a more severe adverse action against an employee with a disability than against a nondisabled employee who engaged in the same misconduct.

A second reason for the importance of a prereferral conference between the prospective examiner and the employer is to better understand the employee's behavioral history, both across the full term of employment and during the recent episode that spurred the referral. This helps the psychologist begin to think about the types and sources of data that may need to be considered during the data-gathering process discussed in Principles 8–11.

Examiners should be careful to recognize the special consideration afforded return-to-work certifications when the employee is released from medical leave under the Family & Medical Leave Act (FMLA) of 1993. Under the terms of the FMLA, an employee generally may not be compelled by the employer to submit to an independent evaluation of his or her fitness for duty once certified by the treating health care provider as ready to return to work, although pre-leave or post-return behavior may justify an FFD evaluation (*Albert v. Runyon,* 1998; see also *Brumbalough v. Camelot Care Centers,* 2005). Thus, when the FFD evaluation referral results solely from information obtained from FMLA disclosures, the employer should be cautioned to consider the *Runyon* decision and to consult with legal counsel before proceeding. On the other hand, when an employer

can establish that it would have ordered an FFD examination *if the employee had not taken leave*, an examination may be permissible (*Carrillo v. National Council of Churches of Christ in the USA*, 1997).

Finally, for referrals involving a federal police agency under the authority of the Office of Personnel Management, federal regulations stipulate that these agencies may not refer an employee for psychiatric or psychological examination unless it has first shown through a physical examination that there is "no physical basis to explain actions or behavior which may affect the safe and efficient performance of the individual or others," and the position has medical standards that call for a psychiatric or psychological examination (5 C.F.R. §339.301(e)(1)). Particularly when an employee is perceived to pose an imminent risk of serious harm to oneself or others, employers often work hastily to obtain an FFD evaluation in short order, and a prereferral conference helps to ensure that these requirements are satisfied before agreeing to conduct an evaluation that may ultimately be deemed invalid under the law.

### Principle 2: Identify the relevant clinical and forensic questions

All mental health assessments are properly driven and constrained by the clinical, forensic, and other questions that prompt the evaluation. Because these questions determine the scope of the examination, the kinds of data that will be gathered, how the data will be analyzed, what judgments or determinations will be made, what information will be disclosed (and to whom), and how it will be communicated, it is essential that the examiner first clarify precisely what the employer wants to know. This is often accomplished by a written referral letter from the employer that specifically lists the questions to be addressed in the course of the evaluation. Alternatively, the examiner can prepare a draft letter of his or her understanding of the employer's referral questions and provide an opportunity for clarification (IACP, 2009, Guideline 7.2). Even when employers do specify their referral questions in writing, they often simply ask the psychologist to evaluate the employee's fitness for duty, without elaboration. But what exactly is the clinical meaning of *fitness for duty*? Alternatively, what does it mean to be *unfit*?

Anfang and Wall (2006) point out that fitness for duty has no consistent clinical definition. They propose a clinically operational definition of *unfitness* as "the inability to perform required occupational duties with reasonable skill and safety as a result of illness or injury" (pp. 676–677). Rostow and Davis (2004) define *unfitness* as "mental impairment that may impact upon the ability of the officer to perform his duty in a safe and effective manner" (p. 62). The IACP Guidelines conceptualize *unfitness* in a police officer as being "unable to safely and/or effectively perform his or her duties due to a psychological condition or impairment" (IACP, 2009, Guideline 3.1).

Other authors have emphasized the importance of distinguishing problems of *unfitness* from those associated with *unsuitability* or *misconduct*. Writing about FFD evaluations in the military, Budd and Harvey (2006) observed that

> there are those individuals whose character structure and the associated attitudes, emotions, and/or behaviors are, in the opinion of the provider, the primary sources of their difficulties in the military. A recommendation for [administrative discharge] should be made when the prognosis for rehabilitation is poor and/or the potential for continued difficulty with occupational demands, misconduct or acting out is high... and these recommendations are channeled through the command's legal department instead of the medical board. (pp. 42–43)

Decker (2006) emphasizes the role of an FFD evaluation in ascertaining whether a law enforcement officer's behavior is simply misconduct or the result of a mental disorder. "If the set of circumstances or the officer's behavior precipitating the FFD evaluation is found to be the result of misconduct, then disciplinary action is the appropriate course" (p. 4). She noted that it is "particularly important to differentiate 'simple misconduct' from bad behavior that is the result of mental

illness" (p. 43). Anfang and Wall (2006) echo the importance of the FFD examiner understanding "the distinction between impairment due to psychiatric illness and inability to perform duties separate from psychiatric illness" (p. 677).

There is no more fundamental issue in an FFD evaluation than how the examiner defines unfitness. Some examiners are reluctant to restrict a definition of unfitness to one requiring a psychological impairment or condition, noting that problems such as interpersonal passivity or timidity, which may be personality based rather than caused by a mental health condition, can also lead to ineffective performance (Stone, 2000). But broadening the definition to include normal range, albeit problematic, behavior poses several risks. First, because the ADA requires a reasonable suspicion of a mental health condition to justify an FFD evaluation, it seems disingenuous to conclude from such an examination that no mental health condition exists but that the employee is unfit for duty anyway. Certainly there are instances where an employee's problematic, disruptive, inefficient, unsafe, or even illegal behavior is caused not by a mental or emotional condition but rather from maladaptive personality traits, character deficits, motivational problems, or other nonpathological factors. These employees may be ill-suited for continued employment, and an administrative decision to terminate their employment may very well be justified. But the fact that an examinee in an FFD examination is a "bad" employee, perhaps even undeserving of continued employment, does not require—legally or ethically—that it is the examining psychologist who should make that determination.* In general, clinical opinions about fitness for duty should rest on evidence that the layperson is not qualified to assess (e.g., signs and symptoms of psychopathology). When judgments about unfitness are based on behaviors and other evidence that an employer, layperson, and psychologist can assess with equal facility—such as in the case of an insubordinate, disruptive, or dishonest police officer whose conduct does not result from a mental health condition—they fall outside the realm of a professional, clinical or "medical" opinion because they are devoid of the special expertise required for such judgments. As Gold and Shuman (2009) note, "[E]valuators should be certain to limit opinions to questions of psychiatric impairment" (p. 261). If examiners conclude or suspect that problematic personality traits; moral turpitude; or deficits in knowledge, skill, practices, or training, unconnected to an underlying psychological condition or disorder, render an employee potentially ineffective, inefficient, or unsafe, they should report this to the referring party and defer any judgments about disposition to the employer (Gold & Shuman, 2009; see also Anfang et al., 2005).

A second risk associated with not linking the definition of unfitness to a psychological condition or impairment is that it increases the potential for the examiner to be misused by an employer with

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* Under most circumstances, the examiner's fitness determination should not directly decide the employee's disposition (i.e., return to duty or not). According to the EEOC,

> A doctor who conducts medical examinations for an employer should not be responsible for making employment decisions or deciding whether or not it is possible to make a reasonable accommodation for a person with a disability. That responsibility lies with the employer. The doctor's role should be limited to advising the employer about an individual's functional abilities and limitations in relation to job functions, and about whether the individual meets the employer's health and safety requirements. (EEOC, 2002, at 6.4)

In the U.S. military, ultimate judgments about fitness are made by the service member's commanding officer, and the examiner's role is limited to providing findings and a recommendation as to whether the service member is deemed unsuitable for continued military service due to a mental health disorder (U.S. Department of Defense, 1997). Likewise, police employers retain the ultimate responsibility for making retention decisions, with proper consideration—not deference—given to the results and recommendations of the FFD evaluation. As noted by the court in *Thompson v. City of Arlington* (1993):

> City and its officials, who have special knowledge of the factors that enter into whether a particular person should serve as a police officer, are better equipped than the health care providers, or other health care experts, to determine whether plaintiff should return to regular duty. (at 1144)

illegitimate motives. Gold and Shuman (2009) point out that "forced FFD evaluations" may be used in an attempt to discredit or even terminate an employee. The authors continue:

> For example, an FFD referral may be made in an attempt to discharge a chronically underperforming employee or as a substitute for discipline, or as a way to gather information to harm the reputation of the [employee] who has brought a complaint against the employer.... Participation in such an evaluation represents a misuse of mental health expertise. (p. 244)

As noted earlier, an officer's inability to perform the essential functions of the position due to a mental or emotional impairment is but one of the two purposes for which FFD evaluations are typically sought by employers and permitted under the ADA. The other purpose is to determine whether an employee poses a "direct threat" due to a medical condition (EEOC, 1991). Employees may be referred for direct threat evaluations whether or not the employer intends to terminate the employee because questions may exist about the potential for the termination itself triggering violence, and how to minimize or manage that risk (Borum et al., 2003). The standards for determining unfitness on the basis of *impairment* or *direct threat* will be discussed under Principle 5 (Identify the legal standard for determining fitness).

The employer's referral may contain other questions that the examiner will be asked to address in the course of the FFD evaluation, and the parameters of each should be fully understood by the examining psychologist before proceeding. These may include questions about disability, industrial vs. nonindustrial causation, particular types of impairment (e.g., memory or other neuropsychological functioning), accommodation, violence risk management, treatment, effects of medications, and restricted or limited duty.*

### Principle 3: Decline the referral if it falls outside your area of expertise or competence

After clarifying the precise clinical and forensic questions, the examining psychologist is better positioned to judge whether he or she has the expertise (i.e., education, training, and experience) to answer the referral questions. Professional ethical standards require that psychologists provide services "with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience" (APA, 2002, Standard 2.01(a)). These standards also stipulate that "[w]hen assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles" (Standard 2.01(f)).

IACP (2009) Guideline 5.1 contains a similar provision, recommending that examiners have the following minimum qualifications:

1. Be licensed as a psychologist or psychiatrist with education, training, and experience in the diagnostic evaluation of mental and emotional disorders
2. Possess training and experience in the evaluation of law enforcement personnel
3. Be familiar with the police psychology literature and the essential job functions of the employee being evaluated
4. Be familiar with relevant state and federal statutes and case law, as well as other legal requirements related to employment and personnel practices (e.g., disability, privacy, third-party liability)
5. Satisfy any other minimum requirements imposed by local jurisdiction or law
6. Recognize their areas of competence based on their education, training, supervised experience, consultation, study, or professional experience
7. Seek appropriate consultation to address issues outside their areas of competence that may arise during the course of an FFD evaluation

* *Restrictions* generally pertain to what an employee *should not* do as a result of a mental or emotional condition, whereas *limitations* refer to what an employee *cannot* do (Anfang & Wall, 2006, p. 677).

Upon fully understanding the clinical and forensic questions pertaining to the FFD evaluation referral, the examining psychologist should carefully and candidly assess whether his or her education, training, and experience are sufficient to adequately address the questions and, if not, whether the shortfalls can be remedied through additional study or consultation with a more experienced colleague. Examples include referral questions that require the psychologist to possess competency in a specialty or proficiency (e.g., forensic psychology, neuropsychology, psychopharmacology), specialized knowledge (e.g., familiarity with ADA case law related to a particular impairment, such as the ability to interact with others), or exceptional experience (e.g., a complex, contested, and/or litigated case with contradictory evidence). Lacking the requisite qualifications, the examiner should decline the referral.

FFD evaluations are often referred to as "high stakes" or "high risk" evaluations (Anfang & Wall, 2006; Borum et al., 2003), and the legal liability to both the examiner and employer can be great. In addition, the stakes are also very high for the employee, for whom an "unfit" finding may be career ending. Ethical standards require that psychologists "take reasonable steps to avoid harming their ... organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable" (APA, 2002, Standard 3.04). Meeting this ethical requirement may demand that some examiners decline the FFD evaluation referral, agree to address just a subset of the questions posed in the referral, or proceed only after obtaining appropriate consultation.

Anfang and Wall (2006) point out that "[t]he legal concepts, evaluation process, and administrative issues may be complex and unfamiliar to the nonforensic clinician.... FFD evaluations can often become the subject of administrative or legal dispute because of the significant personal, legal, and financial consequences" (p. 678), and evaluators may be asked to defend their opinions in deposition and under cross-examination during court testimony. Therefore, when accepting a referral for an FFD evaluation that is known or reasonably anticipated "to be in the context of litigation, arbitration, or another adjudicative process, the examiner should be prepared by training and experience to qualify as an expert in any related adjudicative proceeding" (IACP, 2009, Guideline 5.2). Indeed, Gold and Shuman (2009) advise clinicians performing FFD evaluations to "consider the possibility that litigation or administrative processes may arise from claims requiring mental health assessments. Thus, the specialty guidelines for forensic clinicians may be interpreted to apply to third-party evaluations of all kinds whether litigation has occurred or not" (p. 2).

### Principle 4: Decline the referral if you are unable to be impartial

Standards of professional ethics require that psychologists "refrain from taking on a professional role when personal, scientific, professional, legal, financial, or other interests or relationships could reasonably be expected to (1) impair their objectivity, competence, or effectiveness in performing their functions as psychologists, or (2) expose the person or organization with whom the professional relationship exists to harm or exploitation" (APA, 2002, Standard 3.06). Similarly, IACP Guidelines state that a prospective FFD examiner should decline to conduct an FFD evaluation when his or her objectivity may be impaired (IACP, 2009, Guideline 6.1). (See also the draft revision of the *Specialty Guidelines for Forensic Psychology* (SGFP), American Psychology-Law Society, 2008, Guideline 3.02, Impartiality and Fairness.)

The necessity for impartiality in the FFD examiner also requires that the examiner have no treatment relationship with the officer being examined (cf. Gold & Shuman, 2009; IACP, 2009, Guideline 6.1.2). Anfang and Wall (2006) observed:

> For FFD evaluations, as for most forensic examinations, a comprehensive evaluation often requires review of additional information (i.e., collateral contacts; psychological testing, including validity assessment; and possible third-party or surveillance data) and a neutral objectivity that is different from the typical alliance-based, patient-centered treatment relationship. (pp. 677–678)

This is a view long championed by Greenberg and Shuman (1997, 2007), who argue that, among the salient differences between the testimony of treating psychologists and forensic psychologists, the

former "is a care provider and usually supportive, accepting, and empathic; the forensic evaluator is an assessor and usually neutral, objective, and detached as to the forensic issues" (p. 53). Whereas the therapist's role is to be supportive and to advocate for the client's interests, the forensic evaluator's role is to exercise "untainted and unbiased judgment" (Greenberg & Shuman, 2007, p. 131). Indeed, these roles are "irreconcilably mutually exclusive" (p. 132).

Heilbrun (2001) defines *impartiality* as "the evaluator's freedom from significant interference from factors that can result in bias" (pp. 36–37). Some degree of even implicit bias may be unavoidable, but the "crucial test" involves whether that bias "would keep the evaluator from moving from data to whatever conclusions are best supported by such data" (Heilbrun et al., 2008, p. 102). The consequences of conducting an FFD evaluation when impartiality has been lost or compromised, or even when it appears so to an objective observer, can be significant.

In *Denhof et al. v. City of Grand Rapids* (2007), the examining psychologist, prior to conducting the FFD examination, told the police chief that the relationship between the officer and the department was like a "marriage gone bad" and they were "best off simply separating, for the good of all persons involved" (p. 9). The court concluded that the examining psychologist "was predisposed to finding Denhof unfit for duty" and concluded that it was "hard to see any possibility that [the psychologist] would yield a result other than finding that Denhof should be separated from the police force" (p. 9). This fact, the court decided, prevented the employer from claiming an honest belief in the determination of unfitness from the FFD examination, because "reliance on a doctor who had already made up his mind did not qualify as reasonable reliance" (p. 9).

The pressure to affirm the perceived or stated expectations of the referring party can be significant in these high-stakes examinations. Psychologists who receive repeated referrals from employers, labor groups, or other sources may create what Anfang and Wall (2006) call "incentive biases" to provide opinions favorable to the perceived or stated expectations of the referring party, thus requiring a decidedly vigilant awareness of, and defense against, the various sources of bias (Gold & Shuman, 2009). Conversely, Anfang and Wall point out that "when the forensic examiner is retained directly by the examinee or his attorney, high-stakes cases can potentially lead to dramatically partisan and conflicted circumstances" (p. 678).

Novice examiners sometimes scoff at the notion of impartiality in FFD evaluations, believing that the employer, as client, is the sole beneficiary of the examiner's professional duties, that no obligations extend to the officer being evaluated, and therefore there is no requirement for impartiality. Fisher (2009), however, points out that "psychologists have ethical obligations toward every party in a case, no matter how many or how named" (p. 1). Koocher (2007) agrees, noting that "both the entity requesting the service and the person undergoing evaluation hold a kind of client status in such cases" (p. 380). Writing specifically about FFD evaluations of police officers, Stone (2000) observed, "While the examination is an independent forensic evaluation conducted on behalf of the employer, the employee also has standing as a client. As such, the employee's welfare should be given substantial weight in determining whether and how to undertake the evaluation" (p. 130). The IACP Guidelines explicitly acknowledge this as well:

> Regardless of who is identified as the client, the examiner owes an ethical duty to both parties to be fair, impartial, accurate and objective, and to honor the parties' respective legal rights and interests. Other legal duties also may be owed to the examinee or agency as a result of statutory or case law unique to an employer's and/or examiner's jurisdiction. (IACP, 2009, Guideline 8.2)

Notwithstanding the assertion by many respected FFD examiners that examinees in such evaluations should be advised that they have no "doctor–patient" relationship (Rostow & Davis, 2003; Stone, 2000), several courts and other legal authorities have reached a different conclusion. In *Pettus v. Cole* (1996), the California Court of Appeals found that an employer's examining psychiatrist has a doctor–patient relationship with an employee-examinee even when the examination is performed for the benefit of the employer. Similarly, the Nevada Supreme Court held that individuals examined

by a psychologist for the purpose of determining suitability for employment were "patients" within the meaning of a statute requiring health care providers to make a patient's records available on request (*Cleghorn v. Hess*, 1993). In *McGreal v. Ostrov* (2004), the court held that McGreal, a police officer who was compelled to submit to an FFD evaluation, was a "recipient of mental health services" and enjoyed the rights of confidentiality associated with personal health information. Other courts and authorities also have held that persons compelled to submit to independent medical evaluations are "patients" under the law (cf. *Arkansas Attorney General Opinion*, 2001; *Crandall v. Michaud*, 1992; *Elkins v. Syken*, 1996; *Simmons v. Rehab Xcel, Inc.*, 1999).

### Principle 5: Identify the legal standard for determining fitness

#### *Standards for State and Municipal Police Officers*

Most states have statutes and/or administrative rules that impose some kind of mental requirements on police officers. The remaining 12 states are silent concerning any psychological or mental health criteria for police officer certification, leaving it to each individual agency to determine what standards to use, if any. More than half of the 38 states with these requirements use language identical, or nearly identical, to a California statute that states that any peace officer shall "[b]e found to be free from any physical, emotional, or mental condition that might adversely affect the exercise of the powers of a peace officer" (California Government Code §1031(f)). The case of *Sager v. County of Yuba* (2007) provides an instructive illustration of how these qualifying mandates for police officers can be applied in an FFD examination. In response to the argument of Sager, a deputy sheriff who was found psychologically unfit for duty, that the California Government Code §1031 standards apply only to police applicants rather than incumbent deputies, the court wrote:

> [T]he section 1031 standards must also be maintained throughout a peace officer's career.... At least two of the standards reflect fundamental law enforcement qualifications: good moral character (§ 1031, subd. (d)) and mental fitness (§ 1031, subd. (f)). If Sager's position is correct, an officer who lost his moral compass would be immune from these standards and only subject to a moral character standard if the applicable job description in that department reiterated that standard as a defined duty of that classification of officers. That absurd result highlights the flaw in Sager's position. (at 14)

Hence, the statutory and regulatory requirements in the employee's jurisdiction may also provide the examiner with important guidance regarding the standard for psychological fitness.

#### *Standards for Federal Police Officers*

When evaluating police officers in the federal system who are subject to the requirements of the Office of Personnel Management (e.g., police officers in the Federal Protective Service, Immigration and Customs Enforcement, U.S. Marshals Service, Department of Veterans Affairs), the Rehabilitation Act of 1973 (29 U.S.C.A. §706), rather than the ADA, establishes the procedural and threshold standard. Although the ADA and the Rehabilitation Act share common statutory elements, the associated regulations and case law differ substantively from the ADA in three ways pertinent to FFD evaluations: (1) the threshold for determining when a federal employee may be referred for a mental health evaluation, (2) the standard for medical disqualification of a federal employee on the basis of a medical or mental health condition alone, and (3) the standard for determining a direct threat.

As noted under Principle 1, a federal police agency under the authority of the OPM regulations may not refer an employee for psychiatric or psychological examination unless certain threshold conditions are met (OPM Medical Qualification Determinations, 1995; 5 C.F.R. §339.301). Once these requirements are satisfied, then an FFD examination conducted by a licensed psychiatrist or licensed psychologist "may only be used to make legitimate inquiry into a person's mental fitness to successfully perform the duties of his/her position without undue hazard to the individual or others" (5 C.F.R. §339.301(e)(2)). Thus, like the EEOC regulations that implement and enforce the ADA, the OPM regulations contain two prongs to the determination of fitness, either or both of which may be at issue in an FFD evaluation (EEOC, 2000, Question 5, p. 7): inability to perform essential functions or posing a direct threat.

When the first prong is at issue and behavioral evidence shows that the employee's performance is unsafe or inefficient, the OPM regulations rely on 5 C.F.R. §339.301 (OPM Medical Qualification Determinations, 1995) to show simply that the employee's medical condition is behind the employee's inability to meet the performance standard. However, when relying on the employee's medical condition *alone*, in the absence of inefficient performance, OPM relies on 5 C.F.R. §339.206, which stipulates three elements to the disqualification standard: (1) the medical condition is itself disqualifying with respect to the medical standards of the position, (2) recurrence of the condition cannot medically be ruled out, and (3) the duties of the position are such that a recurrence would pose a reasonable probability of substantial harm (*Slater v. Dept. of Homeland Security*, 2008).

### *Direct Threat*

Under the terms of the ADA, a *direct threat* means a significant risk of substantial harm that cannot be eliminated or reduced by reasonable accommodation (29 C.F.R. §1630.2(r)). Determinations of direct threat must be based on an individualized assessment of the person's present ability to safely perform the essential functions of the job. The ADA stipulates that the determination must be based on a reasonable medical judgment relying on the most current medical knowledge and/or best available objective evidence (29 C.F.R. §1630.2(r)). Furthermore, the following factors must be considered when making the determination: (1) the duration of the risk, (2) the nature and severity of the potential harm, (3) the likelihood that potential harm will occur, and (4) the imminence of the potential harm (29 C.F.R. §1603.2(r); *Anderson v. Little League Baseball, Inc.*, 1992).

The standard for an employer to show that it has met the burden of proving that an employee poses a significant risk of substantial harm is *substantial evidence*, defined as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion" (*Universal Camera Corp. v. National Labor Relations Board*, 340 U.S. 474 (1951), at 477 [citation omitted]; see also *Knill v. Principi*, 2001). However, in assessing whether an employee can perform his or her duties without a significant risk to the safety of the individual or others, the examiner "must consider the nature of the position and the consequences should the employee fail to perform his duties properly" (*Lassiter v. Reno*, 1996/1997, at 1153). In *Lassiter*, the circuit court decided that the employer was not required to show that a U.S. Deputy Marshal with paranoid personality disorder was reasonably likely to become violent, but rather that he posed a significant risk to the safety of himself or others if he did so. The court wrote:

> Given the duties of a deputy marshal, a significant risk to the safety of others can arise not only from an inclination to strike out in violence, but also from a tendency to misperceive the true nature of events.... Placed in unfamiliar circumstances that may or may not be hostile, the deputy marshal must have the ability to decide in an instant whether the use of deadly force is warranted. If an innocent person is injured or killed because a deputy marshal "read... threatening meanings into benign remarks or events[,]" "it is not difficult to imagine the public outrage, let alone the potential liability" to which the federal government would be subjected. (at 40)

Thus, although the EEOC defines *direct threat* to mean "a significant risk of substantial harm" (29 C.F.R. §1630.2(r)), multiple courts have held that where the employee's position implicates the safety of others, and the potential harm is severe, even a low probability that the harm will occur will be sufficient to establish a direct threat (*Butler v. Thornburgh*, 1990; *Hogarth v. Thornburgh*, 1993; *Myers v. Hose*, 1995). Conversely, where the potential harm is not fatal or catastrophic, the examiner usually will be required to demonstrate that the risk is highly probable in order to establish that a direct threat exists (Mariani & Avelenda, 2009).

It is incumbent on examiners to have a "fundamental and reasonable level of knowledge and understanding of the legal standards, laws, rules, and precedents" that apply to the FFD evaluation within the parties' jurisdictions (American Psychology-Law Society, 2008, Guideline 4.04). This is especially critical with respect to the legal standard for determining fitness.

### Principle 6: Determine the examinee's rights and limitations to access to the report and other personal health information

As discussed under Principle 4, it is neither an ethical truism nor a matter of law in all jurisdictions that the examiner–examinee relationship is devoid of the obligations traditionally and statutorily associated with a doctor–patient relationship. This is no less true in the context of an examinee's right to access personal health information gathered or created for purposes of an FFD evaluation (*McGreal v. Ostrov,* 2004; *Pettus v. Cole,* 1996).

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (2000b) gives patients the right to inspect and amend records containing their personal health information (PHI), and psychologists who meet HIPAA's definition of a health care provider are obligated to comply with the Privacy Rule's requirements for disclosure of PHI (see 45 C.F.R. §160.524 and §160.526). HIPAA defines PHI as all "individually identifiable health information held or transmitted by a covered entity or its business associates, in any form or medium, whether electronic, paper or oral" (45 C.F.R. §160.103). As noted by Gold and Shuman (2009), this definition "does not distinguish information generated by employment-related mental health evaluations from records of treatment. Nor does the Privacy Rule explicitly make the purpose for which the information was created of any consequence" (p. 37).

Some psychologists have argued with only partial accuracy that HIPAA's Privacy Rule pertaining to an examinee's right of access to PHI is exempted in an FFD examination under a provision that bars access when the PHI was "compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding" (45 C.F.R. §164.524(a)(ii)). But under this exception, a psychologist may only "deny access to any information that relates specifically to legal preparations but may not deny access to the individual's underlying health information" (U.S. Department of Health & Human Services, 2000, p. 82554). Consequently, examiners covered under HIPAA should include in their initial disclosures to employers and examinees alike the provisions of the Privacy Rule and their own practices relevant to an examinee's access to reports and underlying PHI (Gold & Shuman, 2009). Although the Privacy Rule permits denial of an individual's access to PHI if it is judged by the examiner to be "reasonably likely to endanger the life or physical safety of the individual or another person" (45 C.F.R. §164.524(a)(3)(i)), it is important to keep in mind—and to disclose—that this decision is reviewable.

The HIPAA Privacy Rule establishes a national privacy floor rather than a ceiling, so an examinee may be afforded even more definitive access to PHI by state statutes and administrative rules, related case law, or the terms of a collective-bargaining agreement. Examiners should determine in advance of the examination what jurisdictional or agency rules may pertain to the examinee's access to PHI, including the final written report. In any event, examinees may be denied access to PHI that "was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information," and the grounds for denial on this basis are unreviewable (45 C.F.R. §164.524(a)(2)(v)). A report containing such information should be redacted before giving the examinee access to it.

### Principle 7: Provide appropriate disclosure to the referring party concerning fees, evaluator role, and procedures

Any medical examination compelled by the employer must be paid entirely by the employer (EEOC, 2000, Question 11, pp. 11–12). Still, the examiner's fees, including any differences in rate by type of service (e.g., evaluation versus testimony in court or other adjudicative forum), should be disclosed to the referring party in advance of the service. In addition, the examiner should clarify the nature of the services to be provided, the estimated hours and time period, the provisions if the anticipated services cannot be performed within this period, who will be responsible for payment, any special financial considerations (e.g., fees in the event of cancellations, terms of payment, and interest on delinquent balances), and anticipated work products (e.g., verbal consultation, report, and testimony)

(Heilbrun, 2001). A useful and simple form of disclosure that meets some, although not all, of these disclosure obligations may be accomplished by providing the referring party with a copy of the IACP FFDE Guidelines (2009), along with a statement that these guidelines are expected to apply to both the referring party and the examiner.

Anfang and Wall (2006) advise that it is best to clarify all terms of an FFD evaluation in a letter of engagement, with the letter signed and returned to the examiner before the examination begins. They recommend inclusion of all fees and payment arrangements; cancellation, deposition, and in-court testimony policies; the level of detail that the report will contain; and the precise nature of collateral records and other documents sought in connection with the referral (e.g., job descriptions, performance evaluations, disciplinary records, awards and commendations, complaints and suits, and documentation of previous episodes of impairment and disability). The IACP FFDE Guidelines (2009) also stipulate that the informed consent of the employer, in addition to the examinee, should be obtained (Guideline 8.1).

### Examination and Procedural Issues

This section describes the principles that pertain to the examination itself and apply only when the psychologist has accepted the evaluation referral and when the referring party and the psychologist have agreed to the terms. It presumes that the examiner has:

1. Assessed how the employer has met the legal threshold for mandating a fitness examination
2. Identified the relevant clinical and forensic questions
3. Determined that the referral is within his or her area of expertise
4. Determined that he or she is able to conduct the examination with impartiality
5. Identified the legal standard for determining fitness
6. Determined the examinee's rights and limitations regarding access to the report and other personal health information gathered in the course of the evaluation
7. Provided appropriate disclosure to the referring party concerning fees, the evaluator's role, and procedures

### Principle 8: Provide the examinee with appropriate disclosure and obtain informed consent/authorization

It is a cornerstone of professional ethics in psychology that examiners are to be honest about the nature, purpose, intended uses, and possible outcomes of the evaluation, and this is especially true in FFD evaluations, where the consequence of an employee's failure to cooperate may be loss of employment (Anfang & Wall, 2006). Some clinicians and attorneys assert that true informed consent in FFD evaluations cannot occur because one of the necessary elements of consent—namely, voluntariness—is absent. This view, however, fails to recognize informed consent as a broad ethical obligation "that costs nothing and treats the examinee with respect" (Gold & Shuman, 2009, p. 28). Indeed, the fundamental legal principle underlying the necessity for consent "is now beyond debate" (p. 27).

APA ethical standards (APA, 2002) stipulate that even when informed consent may not be legally required, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, and (3) consider such person's preferences and best interests (Standard 3.10(b)). Thus, whether conceptualized as consent, informed consent, assent, or disclosure, psychologists should always provide the examinee with clarification concerning important elements of the examination. At a minimum, these include:

1. A description of the nature and scope of the evaluation
2. The limits of confidentiality, including any information that may be disclosed to the employer without the examinee's authorization

3. The party or parties who will receive the FFDE report of findings, and whether the examinee will receive a report
4. The potential outcomes and probable uses of the examination, including treatment recommendations, if applicable
5. Other provisions consistent with legal and ethical standards for mental health evaluations conducted at the request of third parties (IACP, 2009, Guideline 8.1)

Although the importance of obtaining consent or, in the alternative, providing disclosure, is an established ethical and legal principle (*Schloendorff v. Society of New York Hospital*, 1914), debate surrounds the appropriate actions of the examiner in the event that an employee refuses to consent to the evaluation. Rostow and Davis (2004) contend that the examiner could proceed under some circumstances, whereas Gold and Shuman (2009) assert that the examination should not take place in the absence of written confirmation of consent, noting that "[f]ailing to obtain a consent later determined to be required cannot be remedied" (p. 28). Anfang and Wall (2006) suggest that the consent form be given to the examinee in advance of the examination in order to facilitate dialogue and consultation with other parties who may be involved with the examinee, including attorneys, union representatives, and treating clinicians. Under no circumstances, however, should an employee be required to waive all procedural rights or liability as a condition of the FFD examination (*Jackson v. Wilson*, 1979).

Even when informed consent is obtained in writing prior to the examination, it should be kept in mind that informed consent is a process, not simply an event. In the course of the examination, the examiner may need to revisit important aspects of the informed consent document in order to clarify, for example, the limits of confidentiality, the purpose of the examination, or the potential outcomes. Some clinicians request that examinees summarize key elements of the informed consent or disclosure document in their own words both to ensure that consent is given knowingly and intelligently, even if not voluntarily, and to enable documentation of that fact in the event of subsequent litigation.

Special attention to an exceptional form of disclosure may be needed in situations where a police officer examinee is asked to discuss or reveal information that could violate the officer's constitutional right to be free from compulsory self-incrimination (Aitchison, 2000). In *Garrity v. New Jersey* (1967), the U.S. Supreme Court ruled that the use of a police officer's statements in criminal proceedings violated the Fifth Amendment guarantee that citizens cannot be forced to be witnesses against themselves. The Court held that "the choice imposed on [the officers] was one between self-incrimination or job forfeiture" (at 497) and ruled that statements which a law enforcement officer is compelled to make under threat of possible forfeiture of his or her job could not subsequently be used against the officer in a criminal prosecution.

Under *Garrity* and its progeny (e.g., *Gardner v. Broderick*, 1968), before a police employer questioning a police officer can discipline the officer for refusing to answer questions, the employer must (1) order the officer to answer the questions under threat of disciplinary action; (2) ask questions that are specifically, narrowly, and directly related to the officer's duties or the officer's fitness for duty; and (3) advise the officer that the answers to the questions will not be used against the officer in criminal proceedings (*Lefkowitz v. Turley*, 1973). Because an FFD examination is a compulsory examination in which the police officer examinee is usually ordered to participate and cooperate fully under threat of discipline or termination for failure to do so, and because information obtained in the examination about the officer's self-incriminating statements could be included in an evaluation report, examiners should be careful to ensure that an employer has issued the required *Garrity* notice before inquiring into matters likely to reveal self-incriminating information.

### Principle 9: Decide whether to permit third-party observers and/or recording devices into the interview

Otto and Krauss (2009) give a detailed discussion of the ethical, clinical, and legal challenges involved in contemplating the presence of third-party observers in an assessment. In particular,

they note the potential impact of the third party's presence on the examinee's participation and—in cases in which psychological testing is administered—test standardization, norms, and security. For purposes of their review, they define a third-party observer as "an individual whose sole purpose is to observe (and perhaps document)—*but not affect*—the psychological evaluation" (pp. 2–3).

Otto and Krauss classified concerns about the presence of third-party observers into four categories: (1) negative effects on the examinee's responses and participation, (2) interruption of the flow of information from the examinee to the examiner, (3) threats to the validity of conclusions that can be drawn from the evaluation, and (4) threats to the security (and future utility) of psychological assessment techniques and tests. With respect to the first of these, they found little empirical evidence to support this concern outside the limited impact of observers on some memory and learning tests. Furthermore, they point out that many other factors common to the psychological evaluation (e.g., examiner and examinee demographic variables, such as race, socioeconomic status, sex; the examiner's style and expectations of the examinee; the examinee's anxiety level; the nature and purpose of the evaluation) "can have greater or similar effects on the psychological evaluation process" (p. 6) but are nonetheless well tolerated by examining clinicians. This includes invited third-party observers such as students and interns.

Concerns over interruption of the flow of information from the examinee to the examiner likewise carry little weight, given the ready availability of the less intrusive alternatives: video- or audio-recording devices. They also note that ground rules could easily be established that prohibit third-party observers from interrupting the flow of information from the examinee to the examiner.

Concerns about the threats to the validity of information that can be drawn from evaluations in which third-party observers were present were also unsupported. Otto and Krauss (2009) point out that a wide array of factors affect an examinee's performance in an assessment, and in forensic evaluation contexts, "threats to validity stemming from the presence of a third party during the assessment are likely to be overshadowed by these other factors—the most important of which being that almost all psychological and neuropsychological instruments have been normed on individuals involved in legal proceedings" (p. 7). They conclude that the presence of third-party observers, "insofar as it constitutes a deviation from standard test administration—is not nearly as well documented, and is likely a lesser threat to the validity of conclusions drawn from psychological test data, than the effects of the litigation" (p. 7).

Finally, Otto and Krauss (2009) conclude that the basis for concerns over the threats to the security and future utility of psychological assessment techniques and tests are easily overcome by "requesting that the observer be someone who is bound to protect test security or request that test administration be recorded and only made available to persons obligated to protect test security (i.e., a psychologist)" (p. 8).

Although courts have been divided on the question of third-party observers in psychological and psychiatric forensic examinations, the greater weight of opinion appears to fall on the side of not permitting their attendance when, notwithstanding the Otto and Krauss (2009) analysis, the examiner objects to it. In *Vinson v. The Superior Court of Alameda County* (1987), the court denied the employee's request to have her attorney present during the FFD examination, noting:

> We were skeptical that a lawyer, unschooled in the ways of the mental health profession, would be able to discern the psychiatric relevance of the questions. And the examiner should have the freedom to probe deeply into the plaintiff's psyche without interference by a third party.... Whatever comfort her attorney's hand-holding might afford was substantially outweighed by the distraction and potential disruption caused by the presence of a third person. (p. 412)

In *Tomlin v. Holecek et al.* (1993), the court concluded that the presence of third parties would lend a degree of artificiality to the interview that would be inconsistent with applicable professional standards and that allowing a tape-recording would be "an undesirable infusion of the adversary process into the examining room" (at 628). In *Galieti v. State Farm Mutual Automobile Insurance Co. et al.*

(1994), the court held that the employee bore the burden of proving the need to record the assessment or have an observer present. In *Ragge v. MCA/Universal Studios et al.* (1995), the court refused the employee's request for a third-party observer as meritless because of the observer's potential to interfere with, or even contaminate, the examination. These court decisions are consistent with the positions of a number of authors on the topic who advise that the presence of third parties unnecessary to the conduct of the evaluation should always be avoided (Gold & Shuman, 2009).

These considerations aside, there is at least one circumstance in which an examiner may be obligated either to permit a third party to observe the assessment or to decline the referral, and that is when the employee is represented by a labor union and is afforded *Weingarten* rights (*NLRB v. Weingarten, Inc.*, 1975). Under the *Weingarten* ruling, an employee in a collective-bargaining group who reasonably believes that an interview or examination may result in disciplinary action against the employee has a right to the presence of a union representative, if requested, although the representative may not interfere with the proceedings. Examiners who object to the presence of third-party observers should respectfully postpone the examination until the referring party has been notified and is able to make a determination to allow or oppose the request. In a case involving a federal corrections officer referred for an FFD evaluation, the examiner's unilateral decision to prevent the employee's union representative from observing the examination resulted in an adverse finding against the employer when the arbitrator determined that the employee's *Weingarten* rights were violated (*AFGE Local 596 v. Department of Justice et al.*, 2007).

### Principle 10: Select multiple sources of clinical and behavioral information, using relevance and reliability as guides

Reliance on multiple sources of information and corroborating important data whenever feasible is a standard practice in forensic evaluations (American Psychology-Law Society, 2008, Guideline 11.02; Heilbrun et al., 2009). Heilbrun (2001) asserts that the use of multiple sources of information in a forensic mental health assessment is an established principle because it (1) enhances accuracy and (2) allows the examiner to check hypotheses generated by one or more of the data sources or measures. The role of third-party information, primarily consisting of documents and interviews with collateral informants, is especially important given the elevated potential in FFD evaluations for either party to provide an incomplete picture of the relevant facts.

But an FFD evaluation is not a fishing expedition wherein the examiner is free to conduct a comprehensive assessment of the employee and scrutinize, measure, and evaluate every aspect of the employee's functioning. Rather, under the terms of the ADA, "[t]he inquiries or examinations must not exceed the scope of the specific medical condition and its effect on the employee's ability, with or without reasonable accommodation, to perform essential job functions or to work without posing a direct threat" (EEOC, 1997, Question 14, p. 10). When it is not yet confirmed whether an employee actually has a medical or mental health condition—as when the referral results from a sudden, adverse change in behavior or work performance that leads to the reasonable suspicion of a mental health condition—the scope of the examination should be narrowed to those conditions reasonably linked to the problem behavior or other objective evidence giving rise to the referral. On the other hand, when an employee with a previously diagnosed condition is referred for evaluation to determine his or her readiness to return to work, the scope of the evaluation must be limited to that condition. In any case, an examination for either inability to perform essential functions of the job or possible direct threat must be narrowly tailored to seek only that information necessary to address those referral questions (Gold & Shuman, 2009).

The IACP FFDE Guidelines (IACP, 2009) provide a useful starting point for selecting sources of information. These guidelines recommend that they include, but not be limited to:

1. Performance evaluations, previous remediation efforts, commendations, testimonials, internal affairs investigations, formal citizen/public complaints, use-of-force incidents, reports related to officer-involved shootings, civil claims, disciplinary actions, incident

reports of any triggering events, medical records, prior psychological evaluations, and other supporting or relevant documentation related to the employee's psychological fitness for duty (Guideline 7.3)
2. In some cases, medical/psychological treatment records and other data (Guideline 7.3)
3. Psychological testing using assessment instruments (e.g., personality, psychopathology, cognitive, specialized) appropriate to the referral question(s) (Guideline 9.1.2)
4. A comprehensive, face-to-face clinical interview (Guideline 9.1.3)
5. Collateral interviews with relevant third parties if deemed necessary by the examiner (Guideline 9.1.4)
6. Examination by a specialist if deemed necessary by the examiner (Guideline 9.1.5)

Heilbrun (2001) cautioned that the information sought and relied on in any forensic assessment

> should be guided by relevance to the forensic issues and the validity of the different sources.... If a given source has little or no accuracy, then it cannot increase the overall accuracy of the evaluation of forensic issues, and will decrease it if given much weight. (pp. 107–108)

When evaluating whether third-party information is reliable enough to justify requiring a medical evaluation, the EEOC lists the following factors: (1) the relationship of the person providing the information to the employee about whom it is being provided, (2) the possible motivation of the person providing the information, (3) how the person learned the information (e.g., directly from the employee whose medical condition is in question or from someone else), and (4) other evidence that the employer has that bears on the reliability of the information provided (EEOC, 2000, Question 12, p. 12). These factors may also aid the examining psychologist in evaluating the reliability of third-party information. The use of multiple sources of information can bolster confidence in findings when the data reveal consistency across sources, because some individuals who might be interviewed in connection with an FFD evaluation may be biased against or in favor of the employee (Heilbrun et al., 2003).

Certainly the most important, but by no means the only, source of information about the employee's fitness for duty is the clinical interview. In addition to standard examination elements, including a mental status examination, FFD interviews should explore all standard dimensions of history: personal, familial, mental health, developmental, educational, legal, military, marital, occupational, and social. The employee's history of substance abuse, stress management, interpersonal conflict management, and occupational adaptation should be explored as well. In particular, it is essential that the examinee be provided with a full opportunity to tell his or her side of the story as it pertains to the issues underlying the referral, including alternative explanations and perspectives.

Job descriptions and job analyses also are valuable sources of information. Borum et al. (2003) point out:

> Even if the psychologist is generally familiar with the job or knows specific abilities identified from other agencies, it is often helpful to obtain a job description from the specific requesting agency to ensure that one is providing the most precise assessment of fit between the examinee's condition and the agency's requirements. (p. 142)

In the previous discussions under Principles 1 and 2, the importance of gathering the employer's objective evidence of functional impairment, performance deficits, or direct threat to the employee or others was emphasized, along with the necessity for obtaining the specific referral questions. This information, in combination with the job description or job analysis, is critical for determining the breadth and depth of other information that may be required, including collateral interviews of supervisors, coworkers, family members, or treating clinicians. As Gold and Shuman (2009) observed:

> The quality and quantity of the information upon which an FFD examination should be based is a function of the risk to which third persons may be exposed, the opportunity of those exposed to the risk

> to affect it by their own actions, and the examinee's interests. For example, when serious bodily harm is a potential risk, collateral data to verify possibly partisan information is a necessary component of competent decision-making. (p. 252)

The selection of data sources will also be driven in part by the forensic decision-making model used by the examiner (Heilbrun, 2001; see also Principle 12) as well as the legal standard for determining fitness (see Principle 5). In FFD evaluations of police officers, public safety and direct threat are *always* implicated in the judgment of fitness and must *always* be a consideration when deciding on the breadth, depth, and type of information and records to gather.

This point is underscored in *Colon v. City of Newark* (2006), in which a police officer, Bazyt Bergus, assaulted Carlos Colon while Colon was detained in a Newark detention facility and Bergus was assigned to detention duties. Bergus's assignment followed a series of investigations, disciplinary actions, and subsequent appeals related to accusations of domestic assault and other violent conduct. Bergus eventually was referred for an FFD evaluation to be done by an independent psychologist. Neither the employer nor Bergus disclosed to the examiner the details of these accusations and investigations, nor was the psychologist given any information regarding Bergus's two previous pre-employment psychological evaluations. The first of these concluded that he exhibited marked animus "towards blacks as well as a tendency towards impulsivity and a history of aggressiveness" and that "if appointed as a police officer he could constitute a danger to the community" (p. 5). The second, conducted 4 years later with the same psychologist, concluded that Bergus was qualified, although with the familiar caveat that he "apparently tried to present a favorable picture by denying many normal, though not socially desirable, characteristics" (p. 6).

Colon eventually sued Bergus and the City of Newark, alleging deprivation of his civil rights, partly on the basis of the official departmental policy of withholding from evaluating psychologists complete psychological and disciplinary histories of officers referred for evaluation. The jury found both Bergus and the City of Newark liable. On appeal, the court affirmed, noting:

> [W]e are satisfied, as was the trial judge, that a reasonable jury could have found... that the defendant demonstrated deliberate indifference to the civil rights of the public, including Carlos Colon, in its official policies governing the supervision and discipline of Bergus as well as the transmission of information for "fitness for duty" evaluations, and that these policies were the motivating force behind Colon's assault. (pp. 12–13)
>
> Further, Bergus was cleared as fit for duty after a psychological evaluation that, in accordance with usual departmental practice, was rendered without benefit of a full and complete historical record of disciplinary charges and psychological profiles (p. 18).

Care should be taken to ensure that the examining psychologist requests, and documents the request for, all records and collateral information relevant to a "full and complete historical record" of the employee's behavior on and off duty.

In addition to requesting records from the employer and conducting collateral interviews of coworkers and supervisors, as may be indicated, Borum et al. (2003) advise, "To ensure a fair and balanced process, it may also be probative for the expert to ask the examinee if there are specific individuals he or she thinks should be interviewed or documents that should be reviewed as part of the evaluation" (p. 143).

As in the *Colon* matter, referrals for FFD examinations most commonly result from on- or off-duty conduct that raises reasonable concerns about an employee's psychological fitness, prompting careful review of the objective facts preceding and surrounding that conduct. Other referrals occur after an officer has requested leave for treatment or recovery from a psychological injury or condition (e.g., Posttraumatic Stress Disorder following an on-duty traumatic incident), often with the agreement of his or her personal health care provider, and subsequently seeks a return to duty. In these "return-to-work" evaluations, the examiner should gather information related to (1) the circumstances that precipitated the medical leave, (2) psychotherapy or treatment records,

and (3) information about "what has happened since the declaration of unfitness and what changes have occurred in the symptoms or impairments that initially caused concern" (Borum et al., 2003, p. 144). These authors go on to note:

> Reliance on third-party information is critical to gauge any changes in thinking, mood, or behavior that may be observable by others and to assess the extent to which they are consistent with the officer's self-report. If the officer has been referred for treatment, the evaluator ordinarily should contact the treatment provider to request records (with written consent of the officer) and to gather, preferably through discussion, relevant information about specific symptoms or behaviors of concern. The treating professional may also have relevant data and opinions about the officer's prognosis. When consulting a treating professional, however, the FFDE examiner must always consider that the provider has a primary alliance with the officer, and that the applicability of any information must be considered in light of the known distinctions between therapeutic and forensic roles. (p. 144)

The ADA permits an employer to obtain only that medical information necessary to determine whether the employee can do the essential functions of the job or work without posing a direct threat (EEOC, 2000, Question 13, p. 12). "This means that, in most situations, an employer cannot request an employee's complete medical records because they are likely to contain information unrelated to whether the employee can perform his/her essential functions or work without posing a direct threat" (p. 12). However, when an employer has a reasonable belief that an employee's present ability to perform essential job functions will be impaired by a medical condition or that he or she will pose a direct threat due to a medical condition, the employer may ask the employee for additional documentation regarding his or her medications or treatment (EEOC, 2000, Question 17, p. 13).

In order for an inquiry into the private life of an employee to be upheld by the courts, it must be made as narrowly as possible; broad, sweeping requests for information are not likely to be valid (Aitchison, 2000). But where an order to produce a request for particular private information—including medical or treatment records—has a direct relationship to job performance, it is likely to be upheld as valid (*Schuman v. City of Philadelphia*, 1979).

The authority of the FFD examiner to require a review of treatment records as an element of the examination was affirmed in the case of *Thomas v. Corwin* (2007). Jana Thomas, a police officer in the Juvenile Unit of the Kansas City Police Department (KCPD), was ordered to submit to an FFD evaluation after she was placed on medical leave by her treating psychologist for work-related stress and anxiety and then was later released for duty. The examining psychologist concluded that Thomas did not appear to have any major psychological disorder, but he could not find her fit for duty in the absence of evidence of effective medical intervention for her anxiety or a change in working conditions to resolve her complaints within the Juvenile Unit. He reported that he could not issue a final report without access to Thomas's medical records. He opined that Thomas's reluctance to disclose her medical records might indicate other reasons for her alleged work-related stress and anxiety, given that her alleged stress reaction appeared to be "disproportional to the problems" (at 524) in the Juvenile Unit. Thomas refused to authorize release of the records, and KCPD fired her. She sued, alleging ADA violations, discrimination, and invasion of privacy.

The district court issued summary judgment in favor of KCPD, and the appeals court affirmed, writing, "We agree with the district court that examining Thomas was vital to operating the Juvenile Unit, and the focused request for a limited portion of Thomas's medical records was no broader or more intrusive than necessary" (at 529). The court went on to conclude:

> By refusing to provide [the examining psychologist] the opportunity to review her medical records and to discover the root of Thomas's stress and anxiety, Thomas created a stalemate in which KCPD had little choice but to terminate Thomas rather than return her to the position from which Thomas's stress and anxiety originated. Thomas's refusal to cooperate with the reasonable requirements of her FFD evaluation and her violation of KCPD's rules of conduct provided the defendants with legitimate, nondiscriminatory reasons to terminate Thomas. (at 531)

Failure of an examining psychologist to obtain psychiatric treatment records in an FFD evaluation also can lead to error and impede the employer's ability to make decisions involving officer and public safety. In *Thompson v. City of Arlington* (1993), the employer sent police officer Ann Thompson for a psychological FFD evaluation once she was released by her treating mental health care providers to return to work following a suicide attempt. The examining psychologist did not review the psychiatric records but determined Thompson fit for duty. In turn, the employer demanded a review of Thompson's psychiatric treatment records, and she refused, leading the employer to place her on indefinite restricted duty. She sued in federal court, alleging, among other things, a violation of her right to privacy. The court dismissed her suit, citing the inevitable limitations of a treating health care provider's return-to-work opinion and the need for an objective one:

> An important, if not the primary, obligation of plaintiff's doctors is to serve her needs. If those doctors were to conclude that plaintiff's return to regular police officer duty would have a beneficial effect on her mental health, their natural leaning would be to take steps to cause her to return to regular duty. They would be extremely reluctant to report to City that she remains unfit to return to regular duty if, from a medical standpoint, such a report could be a factor in delaying or preventing her recovery. (at 1147)

The court went on to distinguish the patient-centered advocacy of the treating health care provider from the independent judgment of the FFD examiner, while noting the critical importance of having access to the records underlying the treating provider's opinions:

> And, as to City's own health care expert, a self-evident fact is that such an expert is highly unlikely to obtain full and candid information if the expert is required to rely on interviews with plaintiff concerning factors that enter into her mental makeup. Common sense says that, if plaintiff has determined that she wants to return to regular police officer duty, there is a serious risk that she will limit the information she provides in an evaluation by City's expert to facts and circumstances she believes would support her claim that she is fit for such a return. If City's expert is to be able to provide a meaningful opinion to City, the expert would be required to have full information, certainly at least as much information as plaintiff's health care providers acquire. The most effective, and only reasonable, method of obtaining that degree of information would be to cause all the information in possession of plaintiff's regular doctors to be provided to City for evaluation by its own expert. (at 1147)

### Principle 11: Assess response style

One of the core features of a forensic evaluation that distinguishes it from therapeutic assessments is the absence of any presumption that the examinee's self-report is accurate (Greenberg & Shuman, 1997; Heilbrun, 2001). In an FFD examination, the potential for the examinee to under- or over-report symptoms; deny, minimize, or exaggerate facts; conceal certain information; or otherwise misrepresent the truth must always be considered, due in large part to the incentives associated with the outcome. The candidate's orientation toward accuracy or inaccuracy in his or her self-report is referred to as *response style.*

Response style is conceived as including four particular styles: (1) *reliable/honest* (factual inaccuracies attributable to misunderstanding or misperception), (2) *malingering* (factual inaccuracies derived from conscious fabrication or intentional exaggeration of symptoms), (3) *defensive* (factual inaccuracies resulting from intentional denial or minimization), and (4) *irrelevant/uncooperative* (resulting from a failure to become engaged in the evaluation or from a refusal to respond fully or at all) (Heilbrun, 2001; Rogers, 1997).

There are two primary means for assessing response style: (1) third-party information and (2) psychological assessment instruments, or tests, with built-in measures of response style. In the previous discussion of Principle 10, emphasis was placed on the importance of gathering third-party information. Its utility is tied not only to the improved depth and breadth of information obtained through collateral sources, but also to its potential for detecting malingering, defensiveness, dishonesty, and uncooperativeness. Melton et al. (1997) observed that "obtaining information contradicting

the client's version of events is probably the most accurate means of detecting fabrication and may be the only viable one with clients who sabotage interview and testing efforts" (pp. 57–58). This is not to say that any given collateral source should be considered more reliable than the examinee, but rather that consistencies and discrepancies across and within data sources are an important means of weighing validity.

Standardized assessment instruments with validity scales or indices, such as the MMPI-2, MMPI-2-RF, PAI, CPI, MCMI-III, and 16PF, also can serve useful roles in evaluating response style, especially when used in conjunction with third-party information. Consideration should always be given, however, to the base rates of these scales in a particular norm group, such that examinees in an FFD evaluation are not judged to be defensive or dissimulating on the basis of validity scales alone when the scale norms were derived from respondents from a decidedly different context (i.e., police applicants in a pre-employment evaluation may not be comparable on validity scales to incumbent employees in an FFD examination) (Heilbrun, 2001). Evidence of frank lying, dissimulation, falsification, or overt concealment should always be reported to the referring party along with any reservations or limitations in the reliability of the examiner's opinions as a result of the employee's response style. In general, however, when the examinee's response style, based on evidence from third-party sources and psychological testing, suggests that his or her responses are unreliable, they should be regarded as less probative than information obtained from other sources with higher reliability.

## Determining Fitness

### Principle 12: Use a model for determining fitness for duty

Heilbrun (2001; see also Heilbrun et al., 2009) argues for the use of a model to help guide the forensic clinician in data gathering, data interpretation, and communication of results. He cites two general models to consider: Morse (1978) and Grisso (1986, 2003). Both have compelling features and applicability to FFD evaluations, although neither was developed for this application. Morse's model offers a straightforward application to a wide range of forensic mental health assessments, including the FFD evaluation, with a focus on three broad considerations: (1) the existence of a mental disorder or condition, (2) the functional abilities relevant to the referral questions, and (3) the strength of the causal connection between the first and the second considerations.

Gold and Shuman (2009) propose an alternative model (Battista, 1988) for workplace evaluations involving questions of impairment. Like Morse's model, Battista's involves the analysis of three elements: (1) *work demand*, which consists primarily of the relevant work skills and other requirements of a particular job, and can be derived most expediently from the job description and/or job analysis; (2) *work supply*, consisting of the employee's performance and employment history, including the ability to perform work functions with or without a social or interpersonal component, but also including the ability to perform simple and repetitive tasks, perform complex or varied tasks, work under stressful versus routine conditions, and work with and without supervision; and (3) *work capacity*, meaning the balance or interaction between work demand and work supply, such that adequate work capacity results in the employee having enough work supply (ability) to satisfy work demand. Because reduced work capacity can result from either work supply falling below work demand, or work demand increasing to surpass work supply, Battista's model provides a useful framework for analyzing and locating the cause(s) for any observed decrease in work capacity.

This model also incorporates the procedural advice of Borum et al. (2003) when conducting FFD evaluations for police officers and other high-risk positions:

> [T]he psychologist must evaluate the degree of fit between the employee's current capacities or impairments and the essential requirements of the position. The assessment can be done by (a) determining if there are psychological or behavioral problems, and if so, evaluating their potential impact on the employee's ability to perform the functions of the job; and (b) determining if there are any significant impairments in the employee's ability to perform essential job functions, and if so, evaluating their cause. (p. 143)

In my own approach to determining fitness, I adopt a blended model that incorporates elements of Morse's and Battista's models, but which is framed within the context of Grisso's (2003). It consists of four analytic components:

1. *Functional Analysis:* Concerned principally with *work supply*, this analysis asks the question, What is it that the officer is able to do, and not able to do, effectively? It considers the officer's work and behavioral *history*, not merely recent or current functioning. It is concerned with both retained and impaired functioning in an effort to obtain as accurate a picture as possible of the officer's past, current, and reasonably anticipated job relevant behavior.
2. *Contextual Analysis:* Not all police work is identical; it varies depending on the nature of the assignment (e.g., patrol versus desk duty, intermittent undercover versus deep and sustained undercover, homicide versus property crime investigations); the volume of calls for service and population-to-officer ratio (i.e., urban, suburban, rural); and other factors affecting the degree of isolation, stress, risk, and other demands associated with the specific position. The contextual analysis considers these and other relevant work demand characteristics, including consideration of what Brodsky (1996) calls "tolerance limits" within which the employee must operate and that are affected by elements outside the employer's control (e.g., civil service rules, union contracts, and organizational culture). At this stage of analysis, familiarity with the demands and milieu of the position is crucial, and an adequate objective analysis may require a site visit, interviews with supervisors and/or incumbents, and review of job analyses and position descriptions.
3. *Causal Analysis:* This component addresses evidence of the existence of a mental or emotional condition that may account for any observed functional deficits. In practical terms, if no mental or emotional condition exists, the analysis of fitness ends here because the minimum requisite condition for "unfitness" is not met. As noted in the discussion of Principle 5, this does not mean the officer should be retained, but only that the officer's behavioral problems are not attributable to a mental or emotional condition and, therefore, do not implicate fitness. This information permits both the employer and employee to explore alternative means for bringing equipoise to the disparity between work supply and work demand. On the other hand, when a mental condition is found to exist, its nexus to any functional deficits must still be determined. In conducting this analysis, it is important to differentiate between work capacity deficits that (1) derive from the examinee's mental or emotional condition, and (2) are caused by factors independent of that condition (e.g., attitude, motivation, skill or knowledge deficits, interpersonal conflicts, and general medical conditions).
4. *Interactive Analysis:* This element is, as Grisso (2003) points out, an assessment of person–context fit. It is concerned with the degree of congruency or balance between *work supply* and *work demand*—what Battista (1988) calls *work capacity*. Naturally, it requires not only an understanding of the examinee's functional abilities and deficits (derived from the functional analysis), but also an awareness of the *work demands*, or the particular job and working conditions of the officer.
5. *Judgmental Analysis:* This component is concerned with the degree of person–context (i.e., work supply–work demand) incongruency required before it can be determined that the employee cannot safely or effectively perform the job. It addresses what Grisso regards as the "ultimate question" (2003, p. 36), which, in the context of an FFD evaluation, is simply, *How much incongruency is enough to warrant a finding of unfitness?* (Note: Whether this ultimate question is most properly answered by the employer or by the examiner is an issue that warrants serious debate (Heilbrun et al., 2009), although the constraints of this chapter prevent it from further exploration. Examiners who object to opining on the ultimate question should make that position known at the time of the referral (see Principle 1). For these examiners, this model would conclude after the interactive component.)

Regardless of what model is used, its usefulness is measured by its ability to bring an organizational structure that constructively guides the selection and organization of data sources and information, promotes effective analysis, and facilitates the communication of opinions and testimony. The use of a poor model, on the other hand, would likely result in a worse outcome than no model at all (Heilbrun, 2001).

## Communicating the Results

The written product of the FFD evaluation is not merely an opinion or judgment about fitness. It is also an explication of that opinion within the confines of the referring party's request and/or governing conditions. Melton et al. (2007) discuss several important ways that forensically oriented reports differ from those written for traditional clinical settings. First, the recipients usually will not be other mental health professionals, but employers, human resource professionals, attorneys, labor unions, and other laypersons unfamiliar with clinical language and meaning. For this reason, Heilbrun (2001) and others recommend that examiners avoid the use of clinical jargon when writing these reports.

A second difference from traditional clinical reports is the likelihood that they will become more broadly distributed to other unanticipated persons and parties, whether through the employer's decisions, administrative procedures, or subsequent litigation. Consequently, "special care must be taken to minimize any infringement on the privacy rights of persons mentioned in the report" (Melton et al., 2007, p. 583).

A third difference is the degree of scrutiny that the report and the author are likely to receive in the course of any adjudicative proceedings or negotiations. Examiners should expect to be asked to provide testimony concerning their opinions and the bases for them, and this testimony may take place in the context of adversarial proceedings, under oath, where a well-written report will facilitate testimony and a poorly written one "may become, in the hands of a skillful lawyer, an instrument to discredit and embarrass its author" (Melton et al., 2007, p. 583).

To these important considerations must be added an essential final difference, and that is the outcomes or consequences at stake in an FFD evaluation of a police officer. In addition to the impact that the findings may have on the decision to retain or terminate the officer, the nature and content of the report could affect the employee's reputation, standing, and career even if retained in his or her position. Furthermore, an unclear and ultimately unhelpful report concerning an officer who represents a direct threat to the safety of others could result in the employer or other trier of fact ordering that the employee be returned to duty notwithstanding the findings of the examiner, thereby potentially jeopardizing safety. Thus, reports prepared in connection with FFD evaluations should reflect the seriousness of purpose, the significance of the potential consequences, the scrutiny they are almost certain to receive or should receive, and the breadth and nature of the audience, both intended and reasonably anticipated, that characterize these examinations.

### Principle 13: Guard the legal and ethical limitations on report content

It is a standard of ethical practice that "[p]sychologists include in written and oral reports and consultations only information germane to the purpose for which the communication is made" (APA, 2002, Standard 4.04(a)). This ethical standard is echoed by the federal HIPAA Privacy Rule (U.S. Department of Health & Human Services, 2000), which states that a covered health care provider must make reasonable efforts to limit disclosure of protected health information to the *minimum necessary* to accomplish the intended purpose of the use, disclosure, or request (45 C.F.R. §164.502(b)(1)). Rostow and Davis (2004) make this point directly when discussing what law enforcement (LE) executives should anticipate receiving in a report from an FFD examiner:

> The LE executive must not expect a complex examination of the officer's life outside of the events connected to the reason for referral.... In general, the department will be given only the information that it must have to meet its public safety and business necessity obligations in the employment context... without revealing protected health information. (pp. 105–106)

The ADA also imposes limits on how much private information can be disclosed to an employer, stipulating that "[a]n employer is entitled only to the information necessary to determine whether the employee can do the essential functions of the job or work without posing a direct threat" (EEOC, 2000, Question 13, p. 12).

Courts have held that FFD examiners who go too far in disclosing confidential aspects of an employee's life or health may be subject to tort action for invasion of privacy. In *McGreal v. Ostrov* et al. (2004), the circuit court ruled that the chief of police and his codefendants "were not entitled to disclosure of anything other than the fitness for duty determination. They were not entitled... to force the disclosure of the intimate and irrelevant details of McGreal's home life" (p. 53). In an earlier California case, *Pettus v. Cole* (1996), the court reached nearly the identical opinion when the FFD examiners disclosed the employee's history of an alcohol use disorder when the referring question was limited only to whether Pettus qualified for disability under the company's benefits plan. The court wrote:

> There is no reason in law or policy why an employer should be allowed access to detailed family or medical histories of its employees, or to the intricacies of its employees' mental processes, except with the individual's freely given consent to the particular disclosure or some other substantial justification. (at 99)

Although it is important for examiners to strike a balance between offering too much detail and too little (see Principle 14), there also are particular facts about an employee that should not be communicated at all. One of these involves the employee's genetic information, defined under the Genetic Information Nondiscrimination Act (GINA, 2008) as including the manifested medical conditions of family members (29 C.F.R. §1635.3(b)). Thus, for an FFD examiner who is performing the examination as an agent of the employer, both *acquiring* information about the employee's family medical history and *disclosing* that information is prohibited under GINA.

Nonforensic clinicians are generally not trained in preparing reports for the lay audience, so particular care must be taken to ensure that the FFD evaluation report does not contain information that exceeds either ethical or legal boundaries. It also is important to be vigilant to the possibility of organizational or administrative limits on the content of a fitness-for-duty report, inasmuch as many police agencies have written policies that specify the constraints on report content.

In *Pettus* (1996), the court noted that, in the absence of a specific authorization from the employee to disclose personal health information, the examining doctor must limit disclosure to a description of the "functional limitations" that may result from the employee's medical condition. As stated by Gold and Shuman (2009), "Advancing the credibility of the examination by providing all information disclosed to an employer risks unnecessary breaches of confidentiality and psychological harm to the examinee" (p. 33).

### Principle 14: Avoid mere conclusory opinions unless otherwise instructed by the referring party

In an effort to avoid reporting too much private information and facing possible legal, civil, regulatory, or professional sanctions, psychologists sometimes choose to limit their reports simply to a "fit versus unfit" statement without further detail or explanation. This strategy might even be requested by the referring party, in which case it is incumbent on the examiner who accepts such a referral to comply with it. But doing so may very well undermine the usefulness of the report, and examiners should consider the consequences of this approach, as well as the alternatives, and discuss both with the retaining party at the outset of the evaluation.

In the federal environment, the Merit Systems Protection Board (*Lassiter v. Department of Justice*, 1993) held that the proper standard when assessing the probative weight of medical opinion in an FFD evaluation is (1) whether the opinion was based on a medical examination, (2) whether the opinion provided a "reasoned explanation for its findings as distinct from mere conclusory assertions" (p. 4), (3) the qualifications of the expert rendering the opinion, and (4) the extent and duration of the expert's familiarity with the condition of the employee. In *Slater v. Dept. of Homeland*

*Security* (2008), the Board concluded that the FFD reports that were "entirely conclusory, devoid of any medical documentation or explanation in support of their conclusions" carried less "credibility and reliability" than one that was "a thorough, detailed, and relevant medical opinion addressing the medical issues of the agency's removal action" (at paragraph 16).

Gold and Shuman (2009) argue in favor of a "reliability" standard for reports and testimony regarding workplace mental health evaluations, and they assert that reliable expert opinion in this context is characterized by four considerations. It should (1) rest on an adequate basis (e.g., dates and details of interviews and examinations; results of psychological testing; school, military, and work records); (2) clearly articulate what opinion(s) or conclusion(s) the examiner draws from the raw data; (3) clearly explain how the examiner reasoned from the raw data to the opinion offered, including the relevant science and its limits; and (4) fairly address these issues from the perspective of alternative explanations (*Gilbert v. Daimler Chrysler Corp.,* 2004; Shuman, 2005; see also American Psychology-Law Society, 2008, SGFP Guideline 13.01, Accuracy, Fairness, and Avoidance of Deception).

Preparing a report that contains these elements of reliability may also facilitate the due process rights of the employee. In the landmark case of *Cleveland Board of Education v. Loudermill* (1985), the Court held that a represented public employee may not be terminated without first giving the employee "oral or written notice of the charges against him, an explanation of the employer's evidence, and an opportunity to present his side of the story" (at 546). Subsequent cases have extended *Loudermill* due process rights to circumstances in which an officer has been dismissed as a result of an FFD evaluation, noting that the terminated employee has a right to understand the psychological "charges" against him, the evidence underlying the charges, and to be given an opportunity to refute them (cf. *Bass v. City of Albany,* 1992; *Bauschard v. Martin,* 1993; *Nuss v. Township of Falls, et al.,* 1985).

When the retaining party requires a mere conclusory opinion in spite of the inherent limitations of that approach, examiners may consider an alternative posited by Stone (2000). He suggests under such circumstances that the examiner prepare two reports: one for the referring party that conforms to the required limitations and a second for the file that explicates the rationale for the opinions and conclusions and is available for use in litigation should it later be required. Whatever approach is used, examiners should make every effort to prepare a report that conforms to the limits of the law, the explicit terms of the referring party's request and policies, and ethical considerations, while also striving to provide sufficient probative value to be useful both in the immediate employment related decisions and any reasonably anticipated adjudicative or administrative proceeding.

### Principle 15: Address causation, treatment, or restoration of fitness, and/or accommodation only if requested by the referring party

The importance of clarifying the relevant clinical and forensic questions in advance of the examination was emphasized in the discussion under Principle 2. It does little to benefit the examiner or any of the involved parties if this task is postponed until after the examination is finished and the report writing begins. But even at this stage, obtaining such clarification is better done late than not at all.

As previously discussed, it is best to obtain the referral source's questions in writing. Evaluators should write their opinions framed as responses to these questions, organized by listing each question, followed by the response. "When specific questions are asked, evaluators should limit themselves to providing opinions and supporting data responsive only to these questions unless otherwise specified" (Gold & Shuman, 2009, p. 153). This is especially true on matters of causation, treatment or restoration of fitness, and accommodation. Offering opinions beyond the limits of the referral questions inappropriately extends into the *disposition* stage (cf. Grisso, 2003) of decision making, which is a matter properly left to the employer.

#### *Causation*

Examining clinicians are often tempted in FFD examination reports to address causation, if only because it is a central element of most clinical training programs and a compelling topic of interest. Clinicians generally are drawn to questions of causation, and in an effort to help explain the employee's condition

or to facilitate treatment, evaluators may be inclined to discuss or opine on causation in the report, notwithstanding the lack of empirical evidence underlying many such opinions. Evaluators should be mindful that causation is not merely a clinical concept, but a legal one, as well, and the definitions and implications associated with each are quite different from one another. Furthermore, for important reasons having to do with risk management, liability exposure, collective-bargaining procedures, and other legal and administrative considerations, the referring party may want the issue of causation to be addressed at another time, by a separate examiner, or not at all. Causation in particular is a concept that carries implications of potential liability both for the employee and the employer, and each party may be differentially helped or harmed by addressing this question prematurely. (Note: *Causation* in this context refers to the etiology—proximate or remote—of the disorder. In contrast, the *causal analysis* discussed as a decision-making component under Principle 12 is concerned with the underlying cause of the employee's functional impairments (i.e., whether the impairment is due to a mental health condition or some other factor). It is not concerned with the cause of the condition itself.)

### *Treatment*

If causation is a compelling topic for clinicians, it pales in comparison to the attraction to treatment. Clinicians generally wish to be helpful, and this is especially true when faced with an examinee that is psychologically injured, suffering, or otherwise distressed. Indeed, when an evaluator concludes that an employee is psychologically unfit for duty, the referring party often requests that the examiner address how fitness might be restored. When this is the case, evaluators should still be careful to limit their treatment recommendations, including modalities and duration, to those for which there is adequate evidence of effectiveness.

Most importantly, examiners should be careful not to *condition* a determination of fitness on an employee's participation in counseling or other therapy. When such a condition is stipulated, it typically is rationalized in one of two ways: either because the examiner believes the employee's current fitness is unlikely to be sustained without additional or ongoing treatment, or because the employee's current unfitness results from a minor impairment expected to respond quickly to treatment. In cases of the former, if the employee's current fitness is so fragile or unstable as to be undone in the foreseeable future without the benefit of ongoing treatment, the examiner should reconsider whether the *interactive analysis* (see Principle 12) justifies the fit-for-duty conclusion. Examiners need not, nor should they, be constrained in their analyses only to the employee's present symptoms and adaptation; they should also consider the known or reasonably anticipated course of the examinee's condition and fitness in light of the individualized assessment.

In cases where the employee is judged currently unfit for duty due to a remediable condition, it is usually more prudent to acknowledge the current unfit status and not address recommendations designed to restore fitness unless requested by the referring party. When an employer requires treatment as an employment condition, some jurisdictions have held that the employer is responsible for the cost of treatment and compensation to the employee for any on-duty time used to engage in treatment (*Sehie v. City of Aurora*, 2005; see also *Todd v. Lexington Fayette Urban County Government*, 2009), where the court reached a different conclusion when the mandated conditions are for the benefit of the employee and not the employer). Furthermore, employees required to engage in treatment can easily come to believe (erroneously) that treatment compliance will or should shield them from consequences for persistent problematic behavior. Unless the referring party has specifically requested the examiner to opine on treatment or restoration of fitness, the report should be silent on this question. When the employer does request treatment recommendations from the examiner, it may be useful to reference the practical guidance of the EEOC:

> Regardless of whether employers believe they are trying to help employees who have medical conditions, employers should focus instead on addressing unacceptable workplace conduct. Employer comments about the disability and its treatment could lead to potential ADA claims (e.g., the employer "regarded" the employee as having a disability or the employer engaged in disparate treatment). (EEOC, 2008, Question 12, p. 12)

### *Accommodation*

Under the ADA, an employer "must provide a reasonable accommodation to the known physical or mental limitations of a qualified individual with a disability unless it can show that the accommodation would impose an undue hardship" (EEOC, 1997, p. 12). A reasonable accommodation is defined as "any change in the work environment or in the way things are customarily done that enables an individual with a disability to enjoy equal employment opportunities" (29 C.F.R. §1630.9). This may include job restructuring, part-time or modified work schedules, reassignment to a vacant position, and providing additional unpaid leave for necessary treatment.

Employers are only responsible, however, for providing a reasonable accommodation to a *known* limitation of a qualified individual with a disability. Even when an employee has a psychological condition that renders him or her unfit for duty, it is not *per se* legally equivalent to a disability under the terms of the ADA. Indeed, some conditions that may not meet the ADA's definition of a disability may nevertheless render an employee unfit for duty. Moreover, except in cases of obvious disabilities, it is generally the case that the employer's obligation to explore accommodation arises only "when the employee tells the employer he is disabled" (*Hammon v. DHL Airways,* 1997/1999, at 445). The employee need not use the word *disabled* or *disability* to formally initiate the accommodation exploration process (*Cannice v. Norwest Bank Iowa N.A.*, 1999); on the other hand, where the employee openly denies having a disabling condition, even an FFD examiner's finding to the contrary may not be sufficient to require accommodation efforts on the part of the employer (*Larson v. Koch Refining Co.,* 1996).

Once an employee specifically requests an accommodation for a work-impairing condition, the employer has an affirmative duty to engage in the "interactive process" to obtain relevant information about the employee's condition and the basis for requesting an accommodation (*Barnett v. U.S. Air., Inc.,* 2000). Thus, employers may prefer, and usually are best advised, to separate questions of reasonable accommodation from the FFD question. However, when in the interests of expediency and/or compassion an employer asks the examiner to make recommendations regarding accommodation, the examiner should become knowledgeable about the types of accommodation that are regarded by the courts as reasonable (e.g., an employer is not required to restructure or reallocate the essential functions of a job as a reasonable accommodation, and the essential functions may include the start and stop time of an employee's work schedule; see *Guice-Mills v. Derwinski*, 1992). Unless the examiner is familiar with the statutes, regulations, and case law pertinent to reasonable accommodation, it is best to inform the referring party that questions about accommodation will be deferred to a separate stage and examiner, even if requested. Under any circumstances, reasonable accommodation is always an employer's decision, not an examiner's.

## CONCLUDING REMARKS

These 15 principles represent established practices informed by law, professional standards, the literature, and experience. In selecting these, I undoubtedly have left out other fundamental practices that seem obvious, are universally accepted, or have little consequence if not carried out. To the extent that I have overlooked a principle of importance, future editions of this *Handbook* may provide a remedy.

As a reflection of law, standards, and experience, these principles will evolve over time. They also will, and should, provoke discussion and debate. But in the interim it is my hope that they also will provide some measure of guidance to psychologists who seek to approach these high-stakes evaluations with the exacting attention to law, ethics, and practice standards that they demand and deserve. Nothing short of human lives is at stake when evaluating the psychological fitness of a police officer, and nothing less than principled work is required from those who do them.

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# APPENDIX 5

# Report: 4th NYPD officer in 4 weeks kills himself

***By msnbc.com***

Feb 14, 2012

A 14-year veteran of the New York Police Department apparently shot himself to death Monday after finishing his shift, becoming the fourth NYPD officer to commit suicide in less than a month, The New York Post reported Tuesday.

Matthew Schindler, 39, finished his shift in Queens, N.Y., and then shot himself under the chin off of the Long Island Expressway in Jericho around 4:30 p.m. ET, sources told The Post. The married father of three had texted his sergeant minutes before to tell him goodbye, The Post reported.

"He was one of the nicest people we ever met," a family friend, Ryan Proce, told The Post. "He's just an all-around great guy."

Nassau County police said he died at the scene from a self-inflicted gunshot wound, according to The New York Daily News.

Officers were called back to the 115th Precinct station, where flags flew at half-staff, reported The Post.

Just eight days ago, another longtime officer, Brian Saar, shot himself in his Suffolk County home after arguing with his wife at a party, sources said, reported The Post. The 20-year veteran was a father to 5-year-old twins.

And last month, a 28-year-old officer killed himself while on duty after receiving a call from his fiancee, who reportedly told him she called his precinct about the depression he was struggling with, The Post said. Terrence Dean shot himself in the head in front of his partner while on the scene of a car burglary in Queens.

Four days earlier, on Jan. 15, Patrick Werner, 23, shot himself in his parents' home in Yorktown Heights after getting into a car accident. Sources told The Post he had been arguing with his girlfriend on his cell phone at the time of the accident.

Counseling is available for troubled police officers through Police Organization Providing Peer Assistance, or POPPA, said The Post. According to the group's website, the network provides confidential help for officers and their families by preventing and reducing psychological issues, marital problems, and substance abuse, among other services.

http://usnews.msnbc.msn.com/_news/2012/02/14/10406675-report-4th-nypd-officer-in-4-weeks-kills-himself

retrieved 4/19/12

# APPENDIX 6

THE REPUBLIC
Columbus, Indiana





# More police officers seek counseling to combat trauma following major crime incidents

TERRY COLLINS Associated Press
First Posted: April 22, 2012 - 4:09 pm
Last Updated: April 22, 2012 - 4:18 pm



SAN FRANCISCO — Two mass killings just 10 days apart sent spasms of shock through the San Francisco Bay area and also took a toll on the police officers who had to sort out the carnage.

In San Francisco, an unusually high number of officers, about 30, sought counseling after witnessing the gory scene following the massacre of five people inside a home.

"Cops see things on a day-to-day basis that the outside world and the average person doesn't," said police union president Gary Delagnes. "But we also go through our range of emotions. We are human."

In Oakland, when officers responded to reports of shooting at a tiny Christian college near the city's airport, they found numerous people dead, dying or wounded in scattered locations.

Sgt. Dom Arotzarena, the city's former police union president, was among the first to arrive. "It was gruesome, and I don't know if that might even be the right word to describe it," Arotzarena said. "It was disturbing scene and I will never forget it. I think we're all going to remember it."

With the toll at seven people dead and three wounded, several of his fellow officers later received counseling to help them deal with the trauma of seeing the bloodshed that investigators have attributed to a former student with a .45-caliber handgun.

While law enforcement officers undergo rigorous training to prepare for the violent side of their jobs, they can also become emotionally affected by what they see and experience. Most major law enforcement agencies have mental health services to help officers deal with traumatic encounters.

Experts say officers are increasingly being encouraged to express their feelings after they have lived through traumatic events like the two mass killings.



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"We're trying to change the culture which has been to never talk about these things, both in the military and in the police department," said Andrew Leeds, a psychologist who counsels Santa Rosa, Calif. police through the department's Employee Assistance Program. "We're making changes and it's slow. But the stigma has been taken away."

Counseling is particularly important, Leeds said, for officers who have been exposed to the line-of-duty death of a colleague, catastrophes, multiple casualties at a crime scene and deaths of innocent people and children.

Without group or private counseling sessions following such episodes, Leeds said, officers can end up suffering post-traumatic stress disorder and physical maladies such as high blood pressure and premature disabilities. The stress also can lead to domestic and substance abuse.

On March 23, San Francisco police came upon what they described as horrific and surreal scene in a row house near City College. Law enforcement sources said five victims were bludgeoned to death with a sharped-edged weapon and a blunt instrument. Several body parts and blood were scattered throughout the house, and the killer had splashed paint and bleach over the scene.

> **"We're trying to change the culture which has been to never talk about these things, both in the military and in the police department," said Andrew Leeds, a psychologist who counsels Santa Rosa, Calif. police through the department's Employee Assistance Program. "We're making changes and it's slow. But the stigma has been taken away."**

The officers were in "fight or flight mode" trying to determine if a killer was still inside the house, said Sgt. Mary Dunnigan, who runs the department's Behavorial Sciences Unit. They quickly calculated that the victims were related because there were framed photos of them — mostly smiling — around the house.

"Your fear center is on high alert as you encounter these bodies around you for the first time and then you see them in these very intimate photos portrayed as a vibrant family," Dunnigan said. "It's profound.

"Police officers are wired to help and save people and they feel sort of defeated when they come upon a scene like that, like it's too late to help, even though they're not at fault," she said.

Within 72 hours, police were getting the first of several debriefings and counseling sessions. Among those who participated were first responders, crime scene and homicide investigators and 911 dispatchers.

Binh Thai Luc, 35, of San Francisco, is being held on $25 million bail after he was charged with five counts of murder. He has pleaded not guilty, and police have not disclosed any motive for the slayings.

In Oakland, as officers arrived to the gruesome scene at Oikos University on April 2, Arotzarena said he saw a woman bleeding profusely outside the building and a dead woman just inside the building's glass front doors. Fearing a gunman was still inside, he used his beanbag gun to shatter the doors.

"We thought we were going to have a possible shootout. I had to ask my officers to go in and there was no hesitation whatsoever," Arotzarena said. "They listened to every word when I said, 'We gotta go! We gotta save people and engage the suspect!'"

Dr. Michael Palmertree, a San Francisco-based psychotherapist who has worked with the Oakland police department for 35 years, said the officers were "in shock after going inside the school and they were exposed to mortal jeopardy."

The officers came across a blood-splattered classroom where several people had been shot and raced to get them out of the building.

"We pulled out five bodies. We didn't know if they were alive or not," Arotzarena said. "We found one body alive. She had a lot of internal bleeding and was gasping for air. She died at the hospital."

One Goh, 43, was arrested and charged with seven counts of murder and three counts of attempted murder in the deadliest campus attack since the shooting at Virginia Tech in 2007. He has not yet entered a plea.

Palmertree, while declining to give detail about the Oakland debriefings, said that some Oakland officers are still seeking counseling related to the fatal shooting of four officers by a parolee in 2009.

Oakland police union president Barry Donelan said officers regularly encounter traumatic situations in arguably one of most dangerous cities in America.

"Our officers here experience more trauma...in one year than most police officers elsewhere would experience in their entire careers," Donelan said.

# APPENDIX 7

# Monitoring Behavior to Assure Reliability©

for

LAW ENFORCEMENT AGENCIES

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# MONITORING BEHAVIOR TO ASSURE RELIABILITY

***TABLE OF CONTENTS***

# INTRODUCTION

This proposal addresses the establishment and maintenance of workplace standards that are sensitive to the reality that all personnel, even those who are very carefully selected, have the potential to be unreliable. Accordingly, this is a proposal to form a workplace that not only enhances ability of workers to perform, it prescribes actions to recognize, intervene and correct faltering behavior at the earliest sign.

The principles for sustaining reliability are well recognized. These concepts build from the idea that keeping the force fit requires continuing effort. This must come from all involved, a team concept in which workers recognize that it is essential to work with superiors to assure that all are functioning effectively. This common commitment includes the acceptance of the need for reliability to be built into the job as a condition to be on duty, at any time.

An example of how these requirements is evident among aircraft crews. Pilots realize that it is essential that they are physically fit and mentally alert. Pilots are expected to report illness or other problems that should remove them from the cockpit (until their difficulty is remedied). Other crew members are also expected to report concerns about their colleagues, not as informants, but as professionals who are doing part of their job because they realize that their safety relies on the fitness of all.

Supervisors have the responsibility of making temporary replacement an acceptable, easily accomplished task, that reinforces the common commitment. In turn, the employer provides opportunities for removed workers to replenish, and returns them to duty when again fit, or to exit those who cannot repair after a fair chance to re-establish themselves. In practical terms, this organizationally provided opportunity to repair further ensures that reporting of reliability concerns leads to outcomes acceptable to the work force. If the only result of reporting were to be fired, such a consequence would in every real way undermine both self and peer reporting. There cannot be a positive outcome unless workers know that when they are really fit, they really will have the opportunity to do their jobs.

The discussion that follows provides an overview of how a monitoring program can be applied, maintained and reinforced as a mutual effort enjoining employees and employers to the common goal of reliability. This discussion is can also be applied to the concept of training trainers, so that company personnel can employ, develop and in every real way, own, their reliability program.

## MONITORING CONCEPTS

Because even the best of employees can stumble, ensuring on-going reliability, the adequacy of their performance, requires continual attention. The important factors are those that would potentially cause workplace problems or personal difficulties that could influence workplace performance. This should occur in an environment in which all recognize the legitimacy of the requirement for reliability and there is shared commitment to assuring it.

### The Workplace Milieu

Employers must rely on information from workers and supervisors to know how organizational, environmental, or other workplace factors are perceived. Knowledge of these perceptions assures that the commitment is shared and that employees comply with the need to sustain their reliability. Loyalty is a two way street, and the foundation of any monitoring program.

### Setting Limits

Workers need to know what is expected of them, what is unacceptable, and held accountable for both. Accordingly, supervisors need to demonstrate the limits of acceptable behavior by reinforcing effective contributions with praise and correcting inappropriateness by constructive criticism or discipline. In one way or another, all workers test the limits of their circumstances, they need to know what earns them praise and what will bring punishment. Defining the standards of performance requires that both consequences are employed.

#### Immediacy

This principle dictates that *as soon as* possible, recognition of the behavior is given. In other words, behavior counts, good behavior earns good consequences and bad behavior results in immediate warning and correction. Immediate recognition leaves no doubt as to what is important. Sometimes early recognition brings attention based on misinterpretation. If approached with a sense of caring, the consequence will be enhanced communication (as well as reinforcement of the principle).

#### Consistency

Being consistent is critical to being fair and justified. Consistency is essential, meaning that desirable behaviors are uniformly recognized (and praised) and undesirable behaviors are not tolerated (and must be corrected).

## What Counts?

Failure to adhere to performance standards, workplace rules and changes in personal coping ability are the factors that require attention and when evident, must receive supervisory response.

### Failure To Perform

Inadequacy in performing duties means that the work isn't being done. Supervisors need to not only recognize when required duties are not being performed to standard (or at all), they should attempt to determine why. Correcting the discrepancy requires repairing the cause of the problem. Additional monitoring assures that the employee understands the seriousness of the issue while providing the opportunity to demonstrate repair. The perceived legitimacy of any supervisory criticism relies on supervisory praise for work well done.

### Failure To Adhere To Rules

Rule breaking constitutes conduct violations that must be recognized and corrected, and for the good of all, disciplined as appropriate. Consequences should occur without delay; there is no better way to reinforce the rule with the employee, and for the experience to serve as an example to others. "Corrective Discipline" is fair, just and immediate is necessary as a potent component of any monitoring program. Yet because of the potency of this factor, it should be applied precisely, with every effort to reinforce personal will to repair. Without such employee commitment, dismissal is a consequence that will be recognized by all as being reasonable.

### Changes In Personal Coping Ability

Failings in managing life's struggles are evident in changes in feelings, behavior, and health. These changes are discussed further in the following section that explains and expands how signs of difficulty develop.

## EARLY WARNING SIGNS

How able anyone is to face life's challenges at any given point of time depends on their native coping ability and the amount of stress that faces them. Some people are quite stress resilient, they have excellent coping skills and effectively resolve the issues that confront them. Reliability programs try identify these individuals through psychological screening, yet regardless of coping ability, anyone can fall on hard times, facing truly significant challenges and many of them. Every challenge takes energy; stress is cumulative.

In the appendix there is a copy of a scale entitled, "Social Readjustment Rating Scale." The authors of this instrument insightfully recognized changes that face us to adjust reduce our reserves, whether or not the adjustment is a supposed advantage (e.g., promotion) or conflict (e.g., death of a close friend). Their point is that the accommodation of the life change comes at the expense of energy, and that everyone has limits to the energy available for coping. As this scale notes, the consequences of having more challenges than resources is distress that can be emotional, a health problem, or both.

The concept of using *early* warning signs is to recognize potential problems right away, while they are more easily repairable and before damage results. It cannot be too early to turn attention to the need. This is especially true when follow-up studies have shown that the added attention prevented further slippage, simply by ensuring the employee reordered priorities and was sure to focus on the issue.

Monitoring personal signs of failing reliability is based on shifts or changes from anyone's normal emotional status. Doctors consider the potential for change by examining the duration of symptoms (how long the symptoms have been present), the frequency of such incidents (how often they happen) and the intensity (strength) with which they are present. In combination, these features indicate the severity of the difficulty of coping and as a result, the degree of risk present.

The appendix contains a listing of "Early Warning Signs; Indicators of Difficulty in Coping." The use of this resource is detailed in the next section.

**EMOTIONAL INDICATORS** (feelings, beliefs, attitudes)

Apathy

Depression is the most commonly encountered form of mental illness. Feeling "blah" or malaise is the most common feature; burned out. When energy is run down there may not be enough to enjoy previously entertaining activity. This is called anhedonia. Of course, sadness is also a part of being depressed, sadness can range from being a little blue to very severe, life threatening levels.

Anxiety

Most frequently depression co-exists with feelings of anxiety, restlessness and agitation. It does not take long for feelings of insecurity to build and for a sense of worthlessness to develop.

Irritability

When a typically nice person becomes cranky, it is a change worth recognizing. Unfortunately being irritable, overly sensitive, defensive, arrogant or argumentative can easily bring the wrong type of attention. Instead of seeing the change as a sign of a stress, it all too easily elicits a response in kind, to include bitterness or a struggle to control. Wouldn't it be nice if someone responded to your crankiness by showing a little caring, asking what was the matter? Sometimes irritability takes the form of aggressiveness that tests limits, such as insubordinate or hostile behavior. Finding out what is going on will better assure repair than using discipline as the first and only option.

Mental Fatigue

When energy reserves are down, the mind doesn't work well. It is harder to shift gears, concentrate or remember. Because of these limitations, stressed out workers are often resistant to change, can't see alternative ways of doing things and doggedly adhere to plans, even when proven to be imperfect.

Overcompensation (Denial)

One way some distressed workers make up the difference for challenges that are too great, is to deny that reality. They exaggerate, can become grandiose, may work unbelievable hours or even start to think they are being undermined by others.

**BEHAVIORAL INDICATORS** (actions, failures to act, wrongdoing)

Withdrawal

The concomitant behavior to the feelings that accompany low energy, are withdrawals at home and the office. Interpersonally, this is the tendency to isolate, nature's way of cutting back on challenge. In relationships this is seen as pulling back, away, becoming less expressive, or alternately, brooding. At the office there may be a change in motivation as seen in failure to innovate or readiness to accept responsibilities. In the more severe instances, obligations will be neglected.

Acting Out

This term is the euphemism for pushing and exceeding limits. Typically this occurs incrementally, so it may not be obvious until there is an incident which may require disciplinary action. Included are abuse of alcohol (usually as self-medication to reduce the pain of suffering), gambling, excessive spending and/or promiscuity.

It is also a frequent occurrence that an employee's loved one is involved in one or more of these behaviors. Doing so shows desperation of the significant other, invariably at the expense of the employee who cannot help from being involved.

Other such violations of prudence include desperate acting out, which breaks workplace rules or the law. These behaviors can also be a "cry for help," a desperate act that says "rescue me." At the low end of this continuum are administrative violations such as being late to work or having accidents. In the extreme are violations of law that easily affect the ability to sustain employment. These too are conceivably on a continuum, ranging from financial irresponsibility and white collar crimes to violence.

Behaviors are the most easily recognized signs of personal distress. Unfortunately, they are often seen only for their surface meaning. Infractions are all too easily dealt with punitively, without interest or understanding of the actual issues. Real solutions, those that ensure reliability, require such appreciation of what lead up to the problem,

why the particular behavior occurred and how come it happened at this time and in this way.

**PHYSICAL INDICATORS** (physical wellness, feeling sick, being sick)

Psychosomatic medicine, illnesses that are influenced by emotions, constitute some 70% of all medical diagnoses. Physical coping abilities breakdown under stress the same as emotional resources do. In combination, the effect is synergistic, each compounds the other.

Preoccupation With Illness

People accustomed to good health know the difference when they feel ill. In the wake of feeling helpless in dealing with their problems, they all too easily lose hope that they will feel better mentally or physically.

Frequent Illness

The body's immune system is reduced when the resources for coping decline. The result is that illness can be more frequent and difficult to tolerate.

Physical Exhaustion

Fatigue is the most frequently encountered physical stress symptom. Low energy is the reason, it makes every action a laborious effort.

Use of Self Medication

As the functioning of the body breaks down under stress people often use over the counter preparations to reduce the distress of physical symptoms. These preparations are for temporary relief. Any resistant dysfunction or prolonged presence becomes more obviously severe and in need of professional intervention.

Somatic Indicators

All of the changes from comfort to discomfort are easily recognized. They range from aches and pains to the ability to comfortably rest or eat. These indicators can escalate quickly, reducing the body's ability to restore and replenish. Under extreme stress emotional and physical difficulties can make living miserable, making the prospect of suicide seem reasonable as a way of stopping the suffering.

## SECURITY ISSUES

Security violations typically occur inadvertently (as accidents) or as "violations" forced by circumstances (such as failing to properly double wrap material for dispatch because the right size envelope wasn't immediately available). Intentional security violations, designed to defy rules and exploit the opportunity, are also explainable, for many of the same reasons.

Reviews of security investigations often reveal that security accidents occurred because of the inattention of an all too busy, over-tasked employee. Other violations involved what were actually the routine practice of activities that "technically" violated security, but were allowed to become the accepted way of doing business because no one held anyone else to the standard. Security is most often reduced to the lowest common denominator (the easiest, most convenient, simplest means), which would make sense, only if SECURITY was not sacrificed in the process.

Security practices that adhere to the letter of the requirement are most likely to avoid problems of every kind and reinforce the corporate sense of security. Failures to use necessary security procedures do the opposite. Security failings should be looked at as not only as performance deficits, but as acts that undermine the perceived importance of security practices. Supervisors have a particularly important role in assuring that security works.

Supervisors become the quality control, quality reinforcement and procedural improvement resource that assures responsibilities are suitably accomplished.
What supervisors need to know is that the most virulent forms of security violation encountered in our nation's experience were not conducted by uncleared outsiders. These serious crimes were the result of CLEARED personnel becoming dissatisfied with their circumstances and using their access to exploit the trust that had been placed in them. Moreover, these cleared personnel did not seek their jobs in order to conduct their treasonous crimes. In fact, none had any intention of becoming violators when they began their work. They became dissatisfied and committed their crimes only after they had been in their jobs for some length of time and had, over time, become disillusioned. Their crimes were efforts to use their situation to their own advantage because their personal needs were greater than the (perceived) barriers to wrongdoing. It was as if they could see no other option; their

circumstances made the (otherwise) unthinkable appear quite reasonable and even justifiable.

Supervisors need to know that in most every espionage case, the perpetrator gave signs of their dissatisfaction. These signs were most often ignored, or in some cases seen only in disciplinary terms. No one took the time to understand what was going on; no one made a commitment to see that the employee worked their problem out; no one raised the specter of more intense monitoring so that the employee perceived it would be more difficult to do more damaging activity. Convicted spies consistently advise, "no one cared, I could do as I pleased - it didn't matter, what I did (espionage) couldn't have been a very bad thing to do because people violated security all the time."

Security cases have been studied exhaustively because of the losses that have been experienced from espionage. What these cases have consistently shown is that the contexts, environments in which the security crime occurs have an important effect on those who are prone to act out their needs. There must be clearly accessible channels for addressing and resolving personal needs or the likelihood increases that disgruntled employees will innovate and justify their own solutions, which may conflict with rules. This is invariably a slippery slope in which increases are incremental; recognizing the signs of potential risk involves both benevolently dealing with personal problems and authoritatively holding to acceptable standards for conduct.

## WHAT TO DO

### The Legitimacy of Getting Involved

Any really great place you have ever worked had little to do with what you did or where you did it; you were part of a team, you felt you made a difference, you belonged. The most frequently used descriptions of desirable work settings involve the interpersonal involvements in which workers care about and for one another. The concept of monitoring is perfectly in keeping with that ethic, this is often a program element that defines the quality of morale, the value of the effort. Monitoring works only when the people monitored are partners, they want it to work because it is by every description, quality management.

### (Potentially) Everything Counts

Reliability is defined by all of its components. Even the very best people can make mistakes. Failures always occur in a context. No one *wants* an accident to happen, yet accidents are more likely to occur when people are fatigued, overburdened or conversely unutilized and bored, resulting in inattentiveness. Very good people can also be affected by problems that develop in their lives, on the job and off. If an employee's difficulty affects their integrity or capacity to perform it is not only legitimate to become involved, it is necessary to ensure the employee knows that their job depends on the repair. This is a supportive partnership, mutual commitment to professional, quality service. Supervisors have the obligation to recognize (potentially) everything, to facilitate improvements and praise special contributions. Otherwise people don't feel they matter. Both supervisees and supervisors should know that they are needed, that their work is important and that they must work together, mutually committed to each other's success.

### The Goal Is To Make Things Work

Not only must the job get done, it must be done right, all of the time. This is reliable performance. People do the work. They must be ready and able to perform their duty. Any needs of workers must be met or the reliability of their work is at risk. Security monitoring recognizes needs, permitting the initiation of personal remedies that are ultimately good for the individual worker and the employer alike.

## WHAT WORKERS CAN DO

• Realize that this assignment involves special circumstances, especially the need for you to be reliable (able to do your job, use good judgement, maintain your integrity).

• If you have difficulties or need assistance, speak with your supervisor. This is being responsible, it's part of the job, the company will do what it can to work with you. You have the obligation to report many kinds of issues, ranging from foreign travel to being arrested; when in doubt, ask your supervisor.

• Help one another. Extend yourself. Let supervisors know of your concerns; you will be helping a troubled coworker. Neglected problems don't get solved, they get worse.

• You and your coworkers should use whatever resources needed to work things out. This includes financial counselors or marriage counselors, whatever the need may be, there are resources to help. Use them.

## WHAT SUPERVISORS CAN DO

- Get involved immediately

  Don't apologize, just do it. The sooner the attention, the less likely the issue will grow.

- Be consistent

  Uniformly, get involved at the same low threshold, no matter who is involved, whenever it happens. Perceptions of favoritism or prejudice are most likely to develop if you are inconsistent.

- Set an example

  Supervisees will take their lead from you. If you have problems, you will be expected to let your supervisors know too. The system works only when it applies equally, to everyone.

## RESOURCES

The whole purpose of this program is to keep valued employees, on the job, working effectively. When problems occur, every effort should be made so that they are dealt with as soon as possible, using whatever resources are reasonable.

Consultation

Personnel issues should be discussed with your superiors, human resource officers, employee relations representatives or other staffers, all of whom are well experienced in dealing with workplace as well as personal problems.

Fitness For Duty Evaluations

When the suitability of an employee to perform duties is in question, the company may request a formal psychological evaluation to define emotional status and readiness to conduct prescribed duties.

Through the Agency...

In the effort of supporting the needs of employees, a variety of services can be identified for employees to use. These include Employee Assistance Program (EAP) elements or professional consultation from employees' own resources, such as the provisions of their health care plans.

Supervisors should refer their troubled personnel to use resources within the company to assist in approaching, intervening and sustaining their relationships with their co-workers.

Where repeated or pervasive difficulties exist, leaders may consider an organizational climate survey. This is a process of interacting with workers to recognize needs, and form focus groups to enhance communication, morale and problem solving abilities within work groups.

# APPENDIX

# SOCIAL READJUSTMENT RATING SCALE

| Life event | Mean value |
|---|---|
| Death of spouse | 100 |
| Divorce | 73 |
| Marital separation | 65 |
| Jail term | 63 |
| Death of close family member | 63 |
| Personal injury or illness | 53 |
| Marriage | 50 |
| Fired from work | 47 |
| Marital reconciliation | 45 |
| Retirement | 45 |
| Change in health of family member | 44 |
| Pregnancy | 40 |
| Sex difficulties | 39 |
| Gain of new family member | 39 |
| Business readjustment | 39 |
| Change in financial state | 38 |
| Death of close friend | 37 |
| Change to different line of work | 36 |
| Change in number of arguments with spouse | 35 |
| Mortgage over $10,000 | 31 |
| Foreclosure of mortgage or loan | 30 |
| Change in responsibilities at work | 29 |
| Son or daughter leaving home | 29 |
| Trouble with in-laws | 29 |
| Outstanding personal achievement | 28 |
| Spouse begin or stop work | 26 |
| Begin or end school | 26 |
| Change in living conditions | 25 |
| Revision of personal habits | 24 |
| Trouble with boss | 23 |
| Change in work hours or conditions | 20 |
| Change in residence | 20 |
| Change in schools | 20 |
| Change in recreation | 19 |
| Change in church activities | 19 |
| Change in social activities | 18 |
| Mortgage or loan less than $10,000 | 17 |
| Change in sleeping habits | 16 |
| Change in number of family get-togethers | 15 |
| Change in eating habits | 15 |
| Vacation | 13 |
| Christmas | 12 |
| Minor violations of the law | 11 |

(From "The Social Readjustment Rating Scale" by T.H. Holmes and R.H. Rahe, Journal of Psychosomatic Research, 1967. Reprinted by permission of the author.)

Looking at the items in the Social Readjustment Rating Scale, you will note that both disappointments and successes require energy to readjust. Also, you may see items that are a little dated; to bring them up to date you should respond to the items about mortgage using a figure of $100,000 rather than $10,000.

What is your score? Check all the items that have applied to you over the past year and add up your score. Scores of less than 150 points suggest a relatively low probability of a serious health change during the next two years. Scores of 150-300 reflect an about even chance, but if your score is over 300 points, you have almost a 90% likelihood that your health may be at risk.

# EARLY WARNING SIGNS:

*Indicators of Difficulty in Coping*

The stress reactions below are presented in categories so that they may be more easily recognized and understood. There is no magic number of these symptoms that suggest difficulty in coping, rather it is the extent to which the noted reaction is a change, that is, different from a person's normal conditions that makes a reaction potentially important. Further, it is the combined presence of symptoms that determines the potency of the problem. Indicators may be isolated reactions or combinations among the three categories listed below. Finally, it is their **duration** (how long the symptoms have been present/how long they last), the **frequency** of such incidents (how often they happen) and the **intensity** (strength) with which they are present that suggests the severity of the difficulty of coping.

## INDICATORS

### EMOTIONAL

Apathy
$ The "blahs"
$ Recreation no longer pleasurable
$ Sad

Anxiety
$ Restless
$ Agitated
$ Insecure
$ Feelings of worthlessness

Irritability
$ Overly sensitive
$ Defensive
$ Arrogant/argumentative
$ Insubordinate/hostile

Mental Fatigue
$ Preoccupied
$ Difficulty concentrating
$ Inflexible

Overcompensation (Denial)
$ Exaggerate/grandiose
$ Overworks to exhaustion
$ Denies problems/symptoms
$ Suspicious/paranoid

### BEHAVIORAL

Withdrawal (avoidance)
$ Social isolation
$ Work related withdrawal
- Reluctance to accept responsibilities
- Neglecting responsibilities

Acting Out
$ Alcohol abuse
$ Gambling
$ Spending spree
$ Promiscuity

Desperate Acting Out (getting attention-cry for help)
$ Administrative infractions
- Tardy to work
- Poor appearance
- Poor personal hygiene
- Accident prone
$ Legal infractions
- Indebtedness
- Shoplifting
- Traffic tickets
$ Fights
- Child/spouse abuse

### PHYSICAL

Preoccupation With Illness (intolerant of/dwelling on minor ailments)

Frequent Illness (actually sick)

Physical Exhaustion

Use of Self Medication

Somatic Indicators
$ Headache
$ Insomnia
- Initial insomnia
- Recurrent awakening
- Early morning rising
$ Change in appetite
- Weight gain
- Weight loss (more serious)
$ Indigestion
$ Nausea
$ Vomiting
$ Diarrhea
$ Constipation
$ Sexual difficulties

# SOURCES OF PSYCHOLOGICAL VULNERABILITY

## (or) ***HOW GOOD PEOPLE GO BAD***

Neil S. Hibler, Ph.D., FAClinP.

**It really isn't a mystery**

Why is it that sometimes even very stable people can have difficulties coping? The answer lies in both the individual and the context in which they must deal with their problems. It's an interaction in which influences can act singly, or in combination, wearing down and overwhelming capabilities. The result is risk to personal comfort, significant relationships, ability to perform on the job, or worse. Living effectively is consuming, it doesn't happen by chance. This handout discusses each of the factors in this equation, explaining how people become vulnerable and what can be helpful in times of need.

**Personal factors that contribute to vulnerability**

Most often we look at people with problems and only see the despair that's before our eyes, let's go back and see some of the issues that can influence ability to deal with problems.

Surely, not everyone is given the same chance to learn about how to cope. Consider that if you were raised in a family that was like a happy television sitcom, you would have been shown how to deal with challenges simply by observing your parents. Effective parents also recognize the importance of exposing kids to demands so as to let them build a sense of confidence, a capacity to problem solve, to deal with disappointment and to support. Children certainly should be protected from abuse and neglect, but not so protected from life that they do not mature with a sense of earned confidence. Effective parenting is hard. If it wasn't in your childhood experience, you didn't pick your parents well.

Only in the past twenty-five years has the importance of dysfunctional families been recognized for their effects on innocent children, who really are victims. They become adults without an effective personal guide or script for life. All they really know is what they do not want (what their parents did). They have to create a plan as they go, which is incredibly difficult. Support groups for adults from dysfunctional families have grown rapidly. These are movements to recognize the innocence of those affected, and their need for practical solutions. Survivors of Incest and Adult Children of Alcoholics (ACOA) are just a couple examples of these efforts.

There is, of course, personal responsibility in facing challenges. That doesn't change, no matter the circumstance. The point is that some people have less basic coping capacity than do others. Yet regardless of the capability, even very competent people can be overwhelmed by external factors when they combine in a context that over stresses. Sometimes life is a struggle just to hold your own, never mind being graceful. That happens to everyone.

**Life *can* be hard, it often is; read on...**

**The challenge: Stress is cumulative**

How much do have on your plate? Surprise! ... it's more than you think. Two processes make that hard to see. First, we tend to deny how much things really can be a pain. Remember Alf, the television character from outer space, "no problem!" (sure). The other reality is that lots of things with which you must deal do not really go away, completely, even after they are supposedly over and settled. Examples are everywhere, here are a few; divorce, death of a loved one, anger over being treated unfairly, new responsibilities that you are still trying to understand, going paycheck to paycheck, do I need to go on? At any given moment all of us are carrying a lot of emotional baggage, some old, some new, it is unavoidable. The result is that our ability to cope can poop out because we are swamped by a personal disaster, but usually it's a gradual pile-up that we don't see as it accumulates, nor understand when we start to get rough around the edges. After all, isn't "nagging" when someone else tells us that we aren't up to snuff? We don't want to see it. That's why others will usually recognize our distress before we do. Their potential to become involved is the last element of the stress equation, supportive effort can help.

**Interpersonal factors; recognition and a chance for support**

Everything happens in a context. Part of that is yours, part is the challenge you face, but the most important of these factors, involves the other people in your life. Our relationships are the arena in which our lives are played, our joys and sorrows created and shared. Those with vibrant, caring interpersonal resources have additional shoulders to carry the burden. Being without such support is easily and understandably lonely and vulnerable. Tragically, personal difficulties are often misunderstood, and opportunities for support missed because of only a superficial appreciation of the influences, particularly the absence/presence/status of personal relationships. This is an opportunity to be part of someone else's problem (by being insensitive), or to contribute to a solution. Wouldn't it be wonderful if others cared enough to reach out to us in ways we could accept. Perhaps there is hope.

A supportive environment starts with someone who is willing to extend him/herself to someone else. That can be by reaching out to give, or to ask for understanding. We will most likely see the rough edges in others before they will realize they are falling from grace. Don't worry about what to say. If you want to understand and help, your words, your effort will be fine. Troubled people most at risk may be in denial, and may reject initial contacts. The very recognition of their awkwardness may make them feel even more vulnerable. We have all done that. Genuine caring isn't easily offended, truly supportive concern not only returns again and again, it sees things through, with interest and assistance that encourages practical results. Our best, most available therapists are the people in our lives who care, and show it.

When it's all said and done, what really does count? Any job you've had that was a joy was worthwhile because of *who* you worked with, not *what* you did. During your adult life you will spend more of your waking hours with others in the work place than with your own family. Whether that time is fulfilling or uncomfortable depends in largest measure on the investments you and your coworkers make in one another. You will get out of it only what you put in. If the workplace is good, continue to be involved, if not, what are you waiting for?

**WHAT TO DO**

Get involved. Here's how. You already know that government employees share a special trust, they must have integrity or their work and the agency they represent are at risk. Because of this need to trust employees your agency must be aware of any behavior that may signal a concerning personal problems that could effect workplace safety and security. History has shown that acts of wrong-doing by workers was preceded by employee dissatisfaction stemming from personal or professional difficulty. Identifying the problem early maximizes everyone's potential to ensure that the matter is appropriately solved. Only your internal security or internal affairs office can really determine if misconduct has already occurred. Extend yourself to your co-worker for day to day support, but your agency needs to be involved with everything else. Intervention will ensure the employee gets help, protecting the trust and integrity we all *must* have.

# APPENDIX 8

# POLICE SUICIDE: FATAL MISUNDERSTANDINGS

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Abstract

POLICE SUICIDE: FATAL MISUNDERSTANDINGS

Neil S. Hibler, Ph.D., FAClinP

One's perceptions are one's reality. This paper reviews themes common in the suicides of uniformed law enforcement officers and special agent personnel. Cases reviewed repeatedly evidence injury to self-esteem and the loss of control. Consistently, suicides reflect the desire to end a struggle, and in so doing, regain control. In every death studied there were viable alternatives to suicide, but the tragic reality was that interventions were not perceived to be viable to the officer at risk. Interventions of all kinds typically underestimate the perspectives and life-space of the at-risk officer. Accordingly, the paper focuses on how to recognize individuals who are failing and enhance efforts to reach out to those in need. The paper concludes with an early warning signs model with which to identify risk, suggestions for creating a work place culture that promotes engaging support and provides program descriptions that have been proven to enhance teamwork, professional commitment and reduce suicide.

Key words: Police suicide, human reliability monitoring, suicide intervention

# POLICE SUICIDE: FATAL MISUNDERSTANDINGS

**Neil S. Hibler**

Suicide is tragic. Police suicide, even more so. The duty of law enforcement is to serve and protect. The loss of a servant at his or her own hand questions why dedicated people who are committed to the safety of others can fall through the safety net that they provide for others. This paper is a review of some of the things that are wrong within the police culture. It focuses on interpersonal, supervisory and corporate failings that neglect those in need and in some instances, even aggravate personal suffering.

It is the thesis of this paper that despite the best of intentions, the failings that contribute to suicide arise from misunderstandings. The types of misunderstandings range from failing to recognize personal suffering, failure to use antidotes that can be effective in neutralizing life's poisons and failing to comprehend the fragile nature of life in the twilight of despair. After briefly considering the phenomenon of suicide, attention is then turned to a model for assuring reliability. This is a prophylactic approach that addresses personal and corporate commitment to problem solving. This paper then concludes with a few, simple suggestions with which to involve members of the force to support anyone who demonstrates they are faltering.

## WHAT IS MISUNDERSTOOD?

Suicide does not just happen. It occurs in a context. This is the key to unlocking what is so often and unnecessarily a mystery. It has to do with fallibility. Unfortunately, the law enforcement profession involves demanding work by prideful people. These are caring individuals who often measure their merit by their successes. Losses, even the appearance of failing are costly, particularly in a culture that is often competitive and can be perceived as unforgiving. It makes sense that such dedicated, ambitious, image conscious professionals do not easily reveal their doubts, struggles or failings. No wonder personal suffering is often hidden, neglected, and misunderstood.

The author's involvement in over fifty law enforcement suicides and post-suicide interventions reveals a number of consistently misunderstood fundamentals. Those who died did not understand that they needed help; instead they had misplaced belief in making it alone. They did not know how to fail, or to survive. Available resources weren't perceived as such. Little was known about what could be done, how to obtain or to accept it. Here are some examples.

Individuals, in the absence of crisis and despair, do not understand the mental state, or mental set, that accompanies difficulty in coping and impending failure. Accordingly, it is easy to deny the pain and suffering, "Not me."

Institutions do no better. Agencies are complex and fail to appreciate or demonstrate effective understandings about many issues confronting personnel. The

contexts from which suicide arises are often addressed by "corporate" programs that are easily seen as lip service. This isn't malicious, not even intentionally superficial. The welfare of personnel is difficult to support and enhance, but little is accomplished by programs that are little more than titles. Their potential is undermined by insufficient understanding of the problem and a lack of commitment to making a difference. What is needed, is a comprehensive conceptualization of police suicide that recognizes and embraces the earliest precursors of risk, and provides a variety of problem solving options that are perceived viable by those at risk. Better yet, deal with the problem before suicide is a possibility.

## SUICIDAL LOGIC

In order to effectively deal with a problem, it must be understood. Rarely is suicidal risk understood. What is needed is as simple as a description of the slippery slope that precedes suicide. It is understandable that individuals who struggle with some personal life circumstance may begin to lose control over their problem. As Schneidman so cogently advises, the purpose of suicide is to seek solution (Schneidman, 1992). Their feelings may become consuming, as despair and frustration become omnipresent. A concomitant physical decline undermines sleep, appetite and recuperation, which accelerates the decline. Under the influence of such a progressive, debilitating experience, there is a narrowing of focus that fails to perceive viable options. This is a shift to a survival mode. Quite simply, when survival in the face of personal crisis is no longer certain, suicide is both an end of the suffering and a way of regaining control. To those who are suffering, suicide is an exit plan, an escape. As suicide researchers know, when a decision is made to end the struggle in the days preceding the death, there is often a sudden sense of calmness and impending relief.

When those who suffer do not know of the path that leads to suicide, their personal comprehension of risk and the self-initiatied opportunity for repair is most often lost. When others do not understand that the risks from failure to solve problems and effectively cope with challanges can lead to suicide, the potential for intervention is lost from those closest and most likely to observe the risk. Peers who cannot recognize personal struggles loose the chance to reach out to their colleagues. Institutions that do not instruct their workers to identify signs of personal suffering loose the chance to provide interventions when they can be most effective.

## INSTITUTIONAL MISUNDERSTANDINGS

Translating practical knowledge about suicide is actually easier than most

institutions seem to realize. Preparing officers to look out for one another capitalizes on the same commitment to reach out and make a difference that police candidates say draw them to the profession.

Cases considered in preparing this paper revealed institutional efforts to deal with suicide that were reactive. The welfare of personnel was questioned only in the face of some critical and tragic incident. Resources were extended following line of duty crises, but personal difficulties that were not duty related only rarely elicited supportive efforts. In many of these suicides it was apparent that personal problems were not considered to be as legitimate as those involved in critical incident debriefings, which were invariably duty related. Yet the common theme among these deaths was personal difficulties, chiefly relationship problems, which typically went unrecognized. The consequence has been a police culture in which suicide risk is not realized in the ways it most often occurs.

Certainly there is everything right with tending to traumatized officers. But what of the officer who more commonly faces challenges that are personal and private, such as failed relationships, failure to thrive and countless other ways to flounder that arise from failing to achieve expectations. In reality, many "institutionalized" support programs miss the point. Among those suffering personal difficulties, institutional programs can be perceived as confirmation of failing and incompetence. One view of the perceptions of law enforcement personnel who have committed suicide suggests the need for a comprehensive intervention program that influences the police culture. It seems what many suicides have made clear is the need to broaden attention from a focus on crisis management to a constructive, programmatic problem solution using resources that are capable and well prepared.

## MISUNDERSTOOD INTERVENTION EFFORTS

"Under-" is the operative prefix to what perhaps would otherwise be reasonable, proactive efforts. Here are some examples: underemphasized, under-funded, understaffed and under-recognized for the importance of such commitment.

Consider this description one "good idea" gone bad. A reasonably large city police force takes pride in having an employee assistance program (EAP) available to everyone on the force. Like most such programs, it is a contract service, contracted to the lowest bidder.

With some sense of pride and interest, this author read in a local paper of the new service and made arrangements to speak with the EAP manager to discuss services the provider was to dispense. Arranging the meeting was something of a challenge. Several phone calls were required, dialing through an assortment of menus before speaking to a

real person. With some reluctance, that real person eventually permitted contact with a representative who consented to getting together, providing long, detailed instructions as how to find the departmental employee assistance office. In actuality, the detailed directions were critical, because the office was virtually impossible to find.

When arriving at the location cited, there were no parking spaces, as I had been forewarned. I had to park three blocks away and then cross a busy highway in order to make my way to the building. Once inside, the EAP title did not appear on the building directory, but following the directions through twists and turns led to an unmarked office door. The program manager explained why it was so difficult to make an appointment and then, to find the office. It was all part of a plan.

In reviewing the pre-existing EAP contract the new firm found that in the pre-existing contract the department was paying for services at the rate of $20.00 per annum for each officer on the force. The new contractor bid $19.75 and, as anticipated, won the contract. When asked what kind of services they could provide for $20 a year for each employee, the answer was confirming, "little or none." The manager then proceeded to describe a variety of activities that were necessary to ensure a profit margin. First, they made a point of having a telephone answering system that required an above-average frustration tolerance in order to get through. For those who were determined, the EAP policy was to make an appointment no sooner than three weeks hence. The concept was that most things blow over in that amount of time, obviating the need for the session.

When I was asked what my interests were, I spoke of attempting to orient staff to the police culture, reducing barriers to intervention and establishing outreach capability. The manager agreed that if "service" was the goal, all of those elements would make sense. He then firmly stated that it was corporate policy to fire any counselor who attempted outreach. He added that in the past they had to let a social worker go because she had asked to go on a ride-a-long. The EAP manager made clear that the intention of the program was to reduce its use so that what was provided was in name only, concluding, "how do you expect us to do any counseling; it's not in the contract cost."

Unfortunately, this is not an isolated example. Another local jurisdiction under-funds their assistance program, using a fee for service model. That program can survive only by finding additional services to provide, each of which is charged on an "as needed" basis. That has led to a variety of creative circumstances, to include requiring everyone within earshot of a shooting to be required to attend not less than six, ninety minute debriefing sessions, whether personnel needed it or not. Officers reported greater destain for the intervention program than for the "traumatic exposure."

In another jurisdiction a police psychologist is engaged in providing more services for less money, ensuring job security while reducing the departmental fees. Accordingly, the same psychologist who does the stress debriefing, does the trauma counseling, and

the fitness for duty evaluations. When officers complained about issues regarding violations of confidentiality and dual relationships, his response to date has been, that is denial of the real problems; treatment resistance.

Here is another example. One military health care program providing medical and psychological support to active duty personnel disqualifies those law enforcement personnel who seek mental health assistance from special duty and in some cases, law enforcement work altogether (Hibler, 1985). The inadvertant result has been to stigmatize military police who need emotional support. Many who have ended their lives have told loved ones that they would rather die than loose their professional status. Those were truly fatal misunderstandings.

What many departments which have experienced suicides have found, is that their employee assistance resource is ineffective. Some are disabled for lack of funding, others do not meet acceptable standards of care. No wonder peer counseling programs frequently are seen as accessible, credible and effective. Officers find that peer counseling equates to credibility, something absent in the design, policy and funding restrictions that limit and undermine the success of other programs. Not surprisingly, peer counselors are often the true front line, and sometimes the only resource that seems credible.

## A COMPREHENSIVE SUICIDE PREVENTION PROGRAM IS REALLY COMMON SENSE RISK MANAGEMENT.

What experience has shown, is that a proactive approach has many advantages to those that are reactive. Perhaps the most important of these is the potential to influence the culture and maintain a milieu in which officers are supported for personal as well as line of duty problems.

Yet rather than making intervention a separate and independent effort, one model has been proposed that empowers supervisors to identify early signs of problems. That pioneering effort by Reiser & Sokol (Reiser, 1971, 1972) has been expanded to peer training, just like first aid buddy care (Hibler, 1985). The point is that when supporting one another and being committed to assisting problem solution, there are cultural values that promote mental health. Emphasis on caring should be integrated into routine departmental business. The goal is to have a complimentary if not synergistic effect that is not only intended to reduce personal difficulties that may lead to suicide, but that may lead to misconduct. In the process, teamwork is enhanced, as is overall morale.

The first component of such a program is a philosophy that recognizes that effective organizations are enhanced and personal risks reduced when there is a commitment to the early recognition of problems and to their sure resolution.

The other component is an orientation program that integrates these concepts from cradle to grave in the development of officers and their culture. The early warning sign model incorporates a simple concept reminiscent of the old addage, "A stitch in time saves nine." The concept is simple. Individuals who begin to falter are different than they normally are; it is ***change*** that makes their struggle recognizable. Furthermore it may not take long for the slippery slope to begin its effect, for when psychosomatic components combine with emotional distress the misery experienced increases at a logarithmic rate. The intent is not to train co-workers and supervisors to be doctors, but rather for them to use their own good common sense and sense of one another so that others do not suffer in silence, or conversely if they are yelling, that they are heard and not simply dismissed as malcontents. A list of some of the features that may become evident as early warning signs has been developed for instructional purposes.

INSERT FIGURE I HERE
(Early Warning Signs)

These are nothing more than a sampling of the sort of emotions, behaviors and physical reactions that occur during distress; they can provide helpful confirmation that most workers already suspect. Accordingly, instead of trying to explain all of the possible indicators, a few are used to illustrate and to legitimize the observer's own common sense. When a change is apparent and concerning, observers are encouraged to address their concerns with the officer. If further attention seems worthwhile, the distressed officer is encouraged to seek peer counseling or EAP intervention. When such efforts are rebuffed or there are risk taking behaviors, officers are encouraged to seek supervisory support. Managers may support, refer or engage fitness for duty procedures if doubts exist regarding suitability to perform duties. The point is, these are complimentary efforts to prevent personal failure and deal with real problems as they really occur. The consequence is to use the opportunity to prevent fatalities by recognizing those struggling with their circumstances, providing support and enabling solutions before the risks are life threatening.

## Summary

Consideration of over 50 law enforcement suicides has resulted in the observation that misunderstandings appear to contribute to risk. These are failures of officers to realize their need for assistance, of colleagues to underestimate their capacity to help and of departments to provide services that are too little and too late. This is a proactive model that is committed to solving problems and is invested in a culture where difficulties are, in

effect, everyone's business when they are out of control. This is a necessary component of real police work that doesn't appear in recruiting posters. Yet resolving problems, as soon as they occur, with compassionate, benevolent resources is a proven method of reducing the causes for and hence the incidence of police suicide.

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**Figure I**

# EARLY WARNING SIGNS:
## *Indicators of Difficulty in Coping©*

The stress reactions below are presented in categories so that they may be more easily recognized and understood. There is no magic number of these symptoms that suggest difficulty in coping, rather it is the extent to which the noted reaction is a **CHANGE**, that is, different from a person's normal conditions that makes a reaction potentially important. Further, it is the combined presence of symptoms that determines the potency of the problem. Indicators may be isolated reactions or combinations among the three categories listed below. Finally, it is their **duration** (how ling the symptoms have been present/how long they last), the **frequency** of such incidents (how often they happen) and the **intensity** (strength) with which they are present that suggests the severity of the difficulty of coping.

### INDICATORS

#### EMOTIONAL

Apathy
· The "blahs"
· Recreation no longer pleasurable
· Sad

Anxiety
· Restless
· Agitated
· Insecure
· Feelings of worthlessness

Irritability
· Overly sensitive
· Defensive
· Arrogant/argumentative
· Insubordinate/hostile

Mental Fatigue
· Preoccupied
· Difficulty concentrating
· Inflexible

Overcompensation (Denial)
· Exaggerate/grandiose
· Overworks to exhaustion
· Denies problems/symptoms
· Suspicious/paranoid

#### BEHAVIORAL

Withdrawal (avoidance)
· Social isolation
· Work related withdrawal
- Reluctance to accept responsibilities
- Neglecting responsibilities

Acting out
· Alcohol abuse
· Gambling
· Spending spree
· Promiscuity

Desperate acting out (getting attention-cry for help)
· Administrative infractions
- Tardy to work
- Poor appearance
- Poor personal hygiene
- Accident prone
· Legal infractions
- Indebtedness
- Shoplifting
- Traffic tickets
- Fights
- Child/spouse abuse

#### PHYSICAL

Preoccupation with illness (intolerant of/dwelling on minor ailments)

Frequent illness (actually sick)

Physical exhaustion

Use of self medication

Somatic indicators
· Headache
· Insomnia
- Initial insomnia
- Recurrent awakening
- Early morning rising
- Change in appetite
- Weight gain
- Weight loss (more serious)
· Indigestion
· Nausea
· Vomiting
· Diarrhea
· Constipation
· Sexual difficulties

# APPENDIX 9

# Recruit Personal Financial Planning

Management and Responsibility

September 2010

1

## Introduction

- What are your financial goals?
- How will you achieve them?
- Do you have a plan for your future?
- Learning to budget and save regularly can provide you and your family with financial security.
- This lesson introduces a fundamental approach to financial planning and saving.

2

## Planning Your Financial Goals

- **Learning Objectives**
  - Identify the three main activities in financial planning
  - Identify the two general purposes of saving
  - Classify expenses as fixed or variable
  - Identify the basic steps to developing a budget
  - Identify the key to proper budgeting
  - Identify the sources available for assistance in financial planning
    - Police and Fire Federal Credit Union
    - City of Philadelphia - Board of Pensions
    - City of Philadelphia - Deferred Compensation

3

## Financial Planning

- **Three Main Activities in Financial Planning**
  - The three main activities in financial planning are:
    - Evaluate your financial status
    - Set financial objectives
    - Plan your budget

4

## Purposes of Saving

- **Two General Purposes of Saving**
  - The principle vehicle that actually takes you to your destination is saving
    - Saving has two general purposes:
      - It enables you to achieve your personal financial objectives
      - It provides you and your family with financial security blanket

5

## Set Financial Objectives

- Personal financial objectives consist of two types: **Short–term and long-term (Handout)**
  - **Short-term** objectives are the building blocks used to attain the long-term objective.
  - **Long-term** objectives are things like buying a home, establishing a business, getting a degree, paying for college tuition, or affording an active retirement. Suppose your long-term objective was to buy a house. What steps would you take to achieve this goal? That is, what would be your short-term objectives? One way to uncover these short-term objectives is to **work backwards**.

6

## Classification of Expenses

- Expenses may be classified in one of two ways: **(Handout)**
  - **Fixed expenses**
  - **Variable expenses**

7

## Plan a Budget

- A budget is a master plan for sound financial management. Your budget helps you set goals for spending (and saving) your money. The sample budget shows how monthly income is allocated. (See handout)
- Notice the three sub-headings:
  - Net Income, fixed expenses, and variable expenses.
- After that, you will see how to plan a budget step-by-step.

8

## Elements of a Budget

- **Net income** – take home pay
- **Fixed expenses** – almost the same every month
- **Variable expenses** – vary from month to month
- Your budget is a plan to spend, and, if properly prepared, it is a master plan for sound financial management. When you draw it up, it is a written agreement you have made with your self. But first, how do you draw it up? **(Handout)**

9

## Developing a Monthly Budget

- 1. Determine your net income
- 2. List your fixed expenses
- 3. List your variable expenses
- 4. Write down what you spend or plan to spend on each fixed and variable expenses
- 5. Total your expenses
- 6. Subtract total expenses
- 7. Determine the amount you can **spend on saving**

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## Key to Proper Budgeting

- The **key to proper budgeting** is to keep complete and accurate records that take all known and foreseeable expenses into consideration.
- After computing, recording, and verifying your figures, you can now analyze your financial situation:
  - Are you spending too much money on clothing or entertainment?
  - Are your automobile expenses higher than you planned?

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## Key to Proper Budgeting

- Since you can easily see where you have overspent or over budgeted, it will now be obvious to you which areas within your budget require adjustment or remedial action.
- On the other hand, if you are within your budget and have income in excess of your expenses, it would be wise to increase the amount of your income allotted to "savings" (assuming that the additional income can be applied toward savings on a regular basis).
- Otherwise, the additional income would be deposited to savings as it occurs. The temptation to spend the extra money as a "reward" for staying in your budget will be great but must be avoided!

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## Key to Proper Budgeting

- Because of the rapid changes in today's economy, your budget must be reviewed and updated frequently, possibly every three months, to be accurate, realistic, and effective. Your budget is of no value unless you "live" within it!
- **Assistance in Budget Planning**
  - Banking Institutions
  - Pension Board
  - Deferred Compensation

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## Choosing a Financial Institution

- How financially informed are you?
- Do you think CD stands for compact disc?
- Do you know how to select the financial institution and savings plan that's right for you; one that will enable you to achieve your long-term financial objectives?

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## Financial Terms

- **The three below pertain to interest:**
  - **Simple Interest** - is an amount of money paid for the use of money.
  - **Accrued Interest** - is interest which has accumulated but has not been paid to the lender.
  - **Compound Interest** - is interest earned over a period of time and is periodically added to and becomes part of the **principal**.
  - **(Handout)**

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## Investments

- **Maturity** - as it applies to investments means the date when full earned payment is due you, the investor.
- **Dividend** - is a payment in cash or stock to the owners (stockholders) from the earnings or capital of the company invested in.
- **Yield** - as used in the financial market, is the annual net return on an investment expressed as percent.
- **(Handout)**

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## Investments

- **The three terms below pertain to financial standing (managing debts).**
  - **Balance sheets** are lists of person's (or company's) assets, minus the liabilities, giving the net worth as of a certain date.
  - **Bankruptcy** is the condition of debtor who has been judged insolvent by a court of competent jurisdiction. If you are forced into bankruptcy, the courts decide how you will repay your debts. If your assets are greater than your liabilities, then you are **solvent**. To file for bankruptcy, you file a court petition saying you are **insolvent**, meaning you do not have enough assets to pay your liabilities.
  - **(Handout)**

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## Property and Loans

- **The three terms below pertain to property and loans. (Handout)**
  - An **asset** is something of value that is owned. You may have to put up one or more of your assets as collateral for a loan.
  - **Collateral** is property or evidence of property that is given to a creditor to guarantee or provide security for the payment of a loan or debt. If you default on a loan (do not pay it back according to the agreement), the lender can seize and sell your collateral.
  - A **lien** is a claim on property usually made to secure payment of a debt or fulfillment of some form of contract obligation.

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## Financial Institutions

- **The four types of financial institutions are:**
  - Commercial Banks
  - Savings Banks
  - Savings and Loan Associations (S&L)
  - Credit Unions

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## Examples of Financial Institutions

- 1. Suppose you wanted your personal finances handled by an institution that offered lending, checking, and saving services. Which type would you choose?
- 2. Suppose you wanted to buy shares in a financial institution that didn't offer its services to the general public and charged a generally lower rate of interest for borrowing. Which type of institution would you choose?
- 3. Suppose you wanted to join a financial institution that offered a somewhat higher rate of interest and may be offered dividends. Which type would you join?

20

## Savings Plans

- Basic savings or traditional account
- Certificate of Deposit (CD)
- Treasury Bonds
- Treasury Notes
- Individual Retirement Accounts (IRAs)

21

## Checking Account

- **Introduction**
  - The checking account is perhaps the most useful, and certainly the most used item in an individual's financial arsenal. But few people keep their checkbooks in good working order.

22

## Checking Account

- **Learning Objectives**
  - Identify the most important reason for having a checking account.
  - Identify the steps to balancing your checking account.
  - Identify the most important thing to remember about managing your checking account.

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## Checking Account

- **Why have a Checking Account?**
  - The most important reason to have a checking account is for safety, it is simply unwise to leave or carry large amounts of cash around! Also, in this day and age, it is highly impractical not to have a checking account. Once upon a time cash was the common method of payment, but, for many reasons, payment by checks had largely replaced payment by cash.

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## Reasons - Checking Account

- Here are some other reasons to have a checking account:
  - **Convenience** – checks save time.
  - **Accuracy** – canceled checks are proof of payment.
  - **Establish credit** – a checking account is a good preference when you apply for a loan, open a charge account, etc.

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## Managing Checking Account

- Most adults have a checking account, but few maintain their account properly. Proper maintenance of your checking account enables you to:
  - Avoid unnecessary fees and penalties
  - Track your spending habits
  - Stick to your budget and savings plan
  - Get the most mileage out of your money

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## Managing Checking Account

- Managing your checking account can be divided into three topics
  - Opening or setting up a checking account
  - Writing and recording checks
  - Balancing your account
  - (Take home handout)

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## Checking Account Services

- Two types of special checking account services offered by some financial institutions are:
  - **Bill paying account** – funds are deposited in your account and the depositor requests the payment of specific amounts for various purposes.
  - **Credit cards to back up checking** – checking accounts can be set up to allow certain credit cards to provide an emergency advance of funds to prevent an overdrawn checking account. This overdraft protection coverage has various names and different methods are used to apply for it. Make sure you understand the repayment procedures and the type of interest rate charged if you choose this type of account.

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## Maintaining Checking Account

- Maintain your Checking Account
  - The last and most important information you need to know about a checking account is that you must **never** write a check in excess of the amount of funds in your checking account!
  - Most financial organizations assess a service charge for processing a "bad check," with a typical charge of $25 or more. And many will not allow you to ever write a check there again!

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## Account Balances

- Available balance vs. actual available funds
  - Calling your financial institution for your available only gives you the amount of money that is currently in your account; it is not the dame as the funds available for use. This balance does not reflect any checks that you may have written but have not yet cleared as well as withdrawals that may not have posted to your account. Relying on this information could cause you to be overdrawn on your account resulting in service for no-traffic funds.

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## Financing Major Purchases

- **Introduction**
  - Any type of planning has these three phases:
    - Determine where you are
    - Decide where you want to be.
    - Plan how to get from here to there.

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## Financing Major Purchases

- Examining Credit
  - **Learning Objectives**
    - Identify credit terminology
    - Identify two disadvantages of using credit
    - Identify six guidelines for using credit
    - Identify six suggested precautions to safeguard your credit cards

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## Financing Major Purchases

- **Learning Objectives**
  - Identify six suggested precautions to safeguard your credit cards
  - Identify general advantages and disadvantages to apply for a loan from three types of financial institutions
  - Identify three undesirable clauses that should be avoided when making a loan agreement.

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## Examining Credit

- **Credit means "buy now pay later"**. Credit permits you to purchase goods or services as you need them, but pay for them over time.
- Uses range from "credit-card shopping" to arranging "loans" from financial institutions for very expensive items.
- Borrowing with credit is so popular in today's society that many of us could not imagine a world without credit, a world in which we would have to wait until we have saved the cash for such things as going to school or buying furniture, automobiles, houses or other items.
- Our national and global economics are very dependent upon the availability of credit to consumers.

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## Examining Credit

- **Credit Terminology (Handout)**
  - **APR (Annual Percentage Rate)** - This indicates the actual cost of a loan per year. It combines the interest charged any fees.
  - **Credit Line** – This amount is the amount of credit a lender will extend to you
  - **Finance charge** – This is usually expressed as interest, percentage of the original loan amount (called the principal).

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## Examining Credit

- **Credit Terminology (Handout)**
  - **Installment Credit** – Installment credit allows a buyer to pay for a purchased item in regular installments, usually monthly payments.
  - **Interest** – is a charge for a financial loan, usually a percentage of the amount loaned.
  - **Open End Credit** – You promise to repay the full balance owed each month with no finance charge assed if the bill is paid in full when due.

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## Examining Credit

- **Credit Terminology (Handout)**
  - **Principal** – This is the original loan amount. Interest is calculated on the principal.
  - **Revolving credit** – This is a line of credit that may be used over and over again. The most common form of revolving credit is a credit card from Visa, MasterCard, or most department store charge accounts.

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## Examining Credit

- **Determine if you should borrow and use credit despite the disadvantages**
  - **The advantages of using credit include:**
    - It's convenient
    - It may be used to meet emergencies
    - It helps you establish credit rating
    - You may get better service on an item
    - You can get earlier use of an item

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## Examining Credit

- There are two main disadvantages to using credit:
  - **Interest costs** - Because companies charge to lend you their money, always add interest costs to the cost of what you are investing in.
  - **Impulse spending** - Probably the biggest disadvantage of credit is that it's so easy to use, it encourages unnecessary spending.

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## Guidelines for Using Credit

- **Six Guidelines for Using Credit**
  - Shop around
  - Pay Cash
  - Ensure it's a wise investment
  - Put as much down as you can
  - Monthly limit
  - Reduce debt

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## Guidelines for Using Credit

- See how much more it would cost you to buy a car on credit for 48 months instead of 36? Sure, the payments are smaller; at 10 percent, they would be $490.56 instead of $385.53. But, you're paying an additional $845 for those smaller payments!

| Interest | Payment Period 36 Months | Payment Period 48 Months |
|---|---|---|
| 10% | $17,660 | $18,505 |
| 15% | $18,969 | $20,305 |
| 18% | $19,783 | $21,432 |
| 20% | $20,336 | $22,202 |

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## Credit Cards

- **Credit Cards (Handout)**
  - The following types of cards are generally lumped into one category:
    - **Credit cards** - allow you to pay back what you borrow at your own pace, provided you pay the minimum due.
    - **Time and Attendance (T&A)** - cards require you to pay the amount in full each month, but they do not charge interest.

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## Credit Cards

- **Credit Cards (Handout)**
  - **Debit** - work like checks, with the amount you spend automatically deducted from your account. (Usually a checking account!)
  - **Charge Cards** - charge cards offered by department stores and oil companies

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## Credit Cards

- Some easy and sensible precautions you can take to safeguard your credit cards and protect yourself from credit card fraud.
  - Sign your credit card
  - Know where your credit cards are
  - Keep a list of cards you use
  - Get rid of any card you no longer use
  - Check your credit card slips

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## Loans

- A loan is a type of credit and is defined as a sum of money lent at interest over a period of time. **(Handout)**
  - **Collateral** is property used to secure the loan
  - **Cosigner** for the lender to secure a loan using a cosigner, another responsible person makes a pledge, in writing, that he, the cosigner, is legally responsible to repay the loan if the borrower does not repay it.

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## Loans

- When you apply for a loan, creditors have 30 days to respond to your application.
- They must give you a reason for denial.
- If it's based on information from a credit bureau, you can contact the bureau and receive a report on your file.

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## Loans

- **Lender's look for the "3 C's" which are:**
  - **Character** – Are you reliable? Do you pay your bills? You may be asked for references or the names of other creditors
  - **Capacity** – Is your income enough to pay the debt? What about other expenses?
  - **Collateral** – Do you have enough assets? (If collateral is not necessary, the loan is called an "unsecured loan".)

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## Loans

- When you take out a loan you sign a loan agreement that should state:
  - The total number of payments and their amounts
  - APR and total finance charge
  - Security agreement, if collateral is pledged

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## Loans

- **A word of caution**: avoid loans designed to consolidate your debts.
- Consolidation loans are intended to help consolidate many debts into one debt and should be avoided if at all possible.
- Your monthly payment for a consolidation loan may be smaller than the total of many monthly debts, but the loan often involves a longer repayment period, with possibly more total interest being paid.

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## Financial Institutions

- Consider these factors when choosing a financial institution for obtaining a loan:
  - Credit rating requirements
  - Interest and fee charges
- Type of Lending Institutions:
  - Credit Union
  - Commercial Bank
  - Finance Company

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## Loan Contracts

- Although federal laws provide some protection to you as a borrower, you need to know all the facts about your loan and understand your loan agreement. **(Handout)**
  - **Promissory note** – When you borrow money, the lender wants some assurances that you are going to repay the loan.
  - **Secured loan** – A loan can either be "secured" or "unsecured".
  - **Truth in lending** – The Consumer Protection Act

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## Loan Contracts

- If it is necessary for you to obtain a loan, you should be on guard for some undesirable clauses in your loan contract, see below:
  - Balloon Payment
  - Prepayment Penalty Clause
  - Confessions of Judgment Clause
  - Purchasing a Motor Vehicle

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## Purchasing a Motor Vehicle

- Identify five extra expense incurred when purchasing a motor vehicle.
- Identify two precautions to take when signing a buyer's contract for a motor
- vehicle.

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## Purchasing a Motor Vehicle

- **Five extra expenses in purchasing a car:**
  - **Taxes (sales and personal property)**
  - **Registration**
  - **Insurance**
    - **Personal Liability**
    - **Comprehensive**
    - **Collision**
  - **Repairs**
  - **Operation/Maintenance**

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## Purchasing a Motor Vehicle

- In the end, the decision to buy new or used boils down to what you can afford and what will give you peace of mind. If you're on a tight budget, then buying a used car can get you the most vehicle for the least amount of money.
- For less than half price of the average new car, you can buy a three or four year old used vehicle that is larger and loaded with more features than the small, barebones new one.

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## Purchasing a Motor Vehicle

- **The Case for Buying Used**
- If you're not married to the ides of buying a new car, used vehicles have their own benefits:
  - **Increased choice**: both new and used-car dealers are feeling the side effects of a tough economy. The positive side of this is that consumers win in a bear market, as dealerships close, prices of large, used SUVs and even midsized cars are down, and there should be more vehicles on lots due to slowing sales.

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## Purchasing a Motor Vehicle

- **Improved reliability**: Although used vehicles typically don't carry the same warranties as new ones, the original factory warranty on a new car transferable to a second owner, usually at no charge. Buyers of certified pre-owned cars from a authorized dealer can purchase a late-model used car with original warranty and then choose to add to it. The combination of glut of late-model used vehicles, the greater reliability and durability of vehicles, and the availability of warranties makes buying a used car less of a gamble.
- **Just like new**: another trend that makes buying used a better option is the proliferation of certified pre-owned programs. The idea started with luxury brands such as Lexus and Mercedes-Benz and has become a popular alternative for car buyers.

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## Purchasing a Motor Vehicle

- **Disadvantages of Using Credit**
  - Using credit can encourage unnecessary spending, using credit for emergencies is convenient, and yet, what exactly constitutes an emergency expenditure? Knowing the difference between designer jeans as an emergency expense as opposed to needing emergency vehicle repair is an understanding necessary for responsible usage of credit.
  - So it's not the number of credit cards you have, it's what you do with them. The key is how you use the credit that you are granted. You can get an excellent credit score by sing only one credit card.

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## Purchasing a Motor Vehicle

- In addition, when buying a **USED** motor vehicle, check to see that the dealer has placed a **"Buyer's Guide"** in the window with information about the following:
  - Any warranty (or an "implied" warranty) coverage
  - Your rights to inspection by a mechanic of your choosing
  - Any potential problems to look out for in a used car

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## Purchasing a Motor Vehicle

- Whether you are buying a new or used car, examine your legal contract. If you have any questions, get legal assistance
  - Before signing, check that
    - All verbal sales "promises" for any contract are written into it
    - Any blank spaces on the contract are crossed out (so the salesperson will not be able to add something later)

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## Purchasing Real Estate

- **Learning Objectives**
  - Identify three family needs to consider before house-hunting
  - Identify three preliminary settlement expenses (in addition to mortgage payments)
  - Identify five types of mortgages

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## Purchasing Real Estate

- **Consideration Factors in Purchasing a Home**
  - Savings plans
  - Family needs:
    - Location
    - Community services
    - Conditions of property
  - Exactly what is a mortgage?
  - Think for a moment of risk. (illness or some type of disaster strikes)
- When you have considered all these factors, you will be able to compare types of mortgages and decide which type is best for your personal financial situation.

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## Purchasing Real Estate

- Consider Preliminary Settlement Expenses
  - **Settlement** - is the legal term for the meeting between you, your lawyer, the seller and his or her lawyer to transfer ownership of real estate
  - **Down Payment** – Amount of money that you pay up front toward the purchase of your home
  - **"Points" on Mortgage Loan** – Points are up-front interest charges levied by banks and mortgage companies
  - **Closing Costs** – Miscellaneous charges, adding up to thousands of dollars, for immediate taxes and legal fees and for establishing your escrow account

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## Mortgages

- You must obtain a mortgage when you purchase a home on credit.
- A mortgage is the monthly payment for the money you borrowed to buy the home.
- Your mortgage payment includes interest charges, taxes on the property, and any insurance coverage.
- A mortgage is a long-term commitment

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## VA Mortgages

- The Veteran's Administration (VA) guarantees loans made to service members, veterans, reservists, and un-remarried surviving spouses.
- VA guarantees loans made for the purchase of refinancing of homes, condominiums, and manufactured homes.
- VA guarantees part of the total loan, permitting the purchaser to obtain a mortgage with a competitive interest rate, even without a down payment if the lender agrees.

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## VA Mortgages

- **Eligibility:** Applicants must have a good a credit rating with an income sufficient to support mortgage payments, and agree to live on the property. To obtain VA certificate of eligibility, complete VA Form 26-1880, "Request for Determination of Eligibility and Available Loan Guaranty Entitlement," and submit it to the nearest VA regional office.
- When shopping for a mortgage, a big question is, "How much can I afford to pay?" You must consider the following:
  - Present and future housing needs. Consider your needs from now through the next 5 to 10 years, as this is the average turnover period in real estate.

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## Mortgages

- Five types of mortgages and their descriptions
  - Fixed Rate
  - Graduated Payment
  - Adjustable Rate Mortgage (ARM)
  - Assumable
  - Balloon

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# APPENDIX 10

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# Law Enforcement Preferences for PTSD Treatment and Crisis Management Alternatives

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# Law Enforcement Preferences for PTSD Treatment and Crisis Management Alternatives

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Abstract

Evidence-based treatments (EBT) for posttraumatic stress disorder (PTSD) remain underutilized. Analog research, however, indicates that patients may be more amenable to receiving EBT for PTSD than utilization rates suggest. This study sought to extend previous studies by investigating PTSD treatment preferences among law enforcement individuals (i.e., active duty officers, cadets, criminal justice students). We asked 379 participants, with varying trauma histories, to read a police traumatic event and imagine they had developed PTSD. Participants rated the credibility of six treatment options which they might encounter in a treatment setting, and chose their most and least preferred treatments. Next, they evaluated a widely used debriefing intervention aimed at preventing PTSD. Almost 90% of participants chose exposure or cognitive processing therapy as their first or second most preferred treatment, and they rated these interventions as significantly more credible than the other 4 treatment options. The sample showed ambivalence regarding the perceived efficacy of debriefing but found the rationale credible. This study supports previous analog research indicating that patients may be more interested EBT than indicated by utilization rates, and suggests that law enforcement departments should consider offering EBT to officers who develop PTSD.

Keywords: Evidence-based, CBT, PTSD, exposure, CISD, police

## 1.1 Introduction

Dissemination of evidence-based treatment (EBT) remains a significant challenge for the field of clinical psychology (Young, Connolly, & Lohr, 2008). For instance, research indicates that one of the most efficacious treatments for posttraumatic stress disorder (PTSD), exposure therapy (Foa, Keane, & Friedman, 2000), continues to be underutilized in clinical practice (Becker, Zayfert, & Anderson, 2004; Foy et al., 1996; Rosen et al., 2004). This trend is disturbing given that research suggests that cognitive behavioral treatments (CBT), such as exposure, can substantially reduce PTSD symptoms and also can be successfully delivered by community therapists (see Cahill, Foa, Hembree, Marshall, & Nacash, 2006 for discussion). It should be noted that dissemination findings are not unique to CBT for PTSD. For example, research also indicates that therapists do not use exposure for other anxiety disorders (Freiheit, Vye, Swan, & Cady, 2004).

Clinical underutilization of EBT may result from a variety of therapist and patient factors (Becker, Darius, & Schaumberg, 2007). Therapist factors that may contribute to EBT underuse, for instance, include lack of training or comfort in delivering EBT, perceptions about interventions, and/or personal preferences for certain types of therapy. Patient factors include, but are not limited to, credibility of treatment rationale, anticipation of discomfort, and/or willingness to tolerate discomfort. Therapist factors and patient factors also may interact. For example, a therapist may lack comfort in delivering a given EBT – possibly because of lack of training. If a patient finds the description of the treatment anxiety provoking, the therapist and patient may collude in avoiding a challenging yet potentially efficacious treatment strategy.

Although previous research provides support for the role of therapist factors in limiting use of EBT for PTSD (Becker et al., 2004; Najavits, 2006; Rosen et al., 2004), prior studies have not clearly implicated patient factors in limiting use of EBT. For instance, three analog studies conducted with student samples (Becker et al., 2007; Tarrier, Liversidge, & Gregg, 2006; Zoellner, Feeny, Cochran, & Pruitt, 2003) consistently found that a sizeable majority of

participants ranked CBT interventions with a strong evidence base (including those that involved exposure) as highly preferred over other forms of psychotherapy and/or medication. This finding was replicated in one non-collegiate sample of women who responded to advertisements seeking females with trauma histories (Angelo, Miller, Zoellner, & Feeny, 2008). Seventy-one percent of the Angelo et al. sample had experienced a Criterion A event and 53% met PTSD criteria. Approximately 82% of participants chose exposure when given a forced choice option of exposure, versus 13% for sertraline and 6% for no treatment. In this study, treatment mechanism (e.g., I need to talk about what happened) was the most commonly cited reason for choosing a treatment, followed by treatment efficacy and health concerns.

To our knowledge, aside from Angelo et al. (2008), no study has examined a predominately non-collegiate sample's perceptions of PTSD treatment options. Furthermore, because Angelo et al. only gave participants the option of one type of psychotherapy (exposure) versus medication or no treatment, no study has explored perceptions about different types of psychotherapy along with medication in a non-collegiate population at high risk for traumatic events. Thus, Angelo et al.'s results may indicate that participants preferred psychotherapy to medication and that the rationale for psychotherapy made more sense than that for medication. In sum, this study does not provide information about perceptions of different types of psychotherapy, with varying levels of empirical support, in a largely non-collegiate sample.

Law enforcement professionals may be at risk for significant exposure to traumatic events. Such events include, but are not limited to, line of duty deaths, serious injury to police, school or workplace shootings, witnessing suicides, police shooting individuals in the line of duty, familial violence, handling dead bodies, and mass fatality terrorist attacks such as 9/11 (Miller, 2006; Volanti et al., 2006). Although law enforcement culture may lead to a perception that officers can psychologically cope with these intense, repeated stressors (Wright, Borrill, Teers, & Cassidy, 2006), research regarding post-trauma symptomatology suggests otherwise. For example, Dowling, Moynihan, and Genet (2006) reported 68% of 9/11 responding officers

reported at least one disaster related stress symptom 15-27 months later, with at least 20% having significant difficulties such that they were advised to seek further assistance. Wright et al. found that 37% of prison officers met criteria for PTSD 3-7 months after a death in custody episode, and Violanti et al. (2006) found that almost 30% of a random stratified sample of officers from an urban police department endorsed moderate to severe PTSD symptoms. Law enforcement personnel who experience stressful or traumatic incidents also may be more likely to leave the job within several years, and appear to struggle with suicide, substance abuse, spousal abuse and divorce at rates that are substantially higher than seen in the general population (Dowling, et al. 2006; Miller, 2006). Thus, it is not surprising that a professional and popularized literature now exists with the aim of addressing the needs of police coping with stressful events (e.g. Artwohl & Christensen, 1997; Klinger, 2004; Kates, 1999).

As noted above, however, law enforcement personnel may view themselves as immune to stressful events and are sometimes reluctant to seek mental health services. As Miller (2006, p.96) notes: whereas some officers are amenable to psychotherapy, “other cops would rather swim through boiling oil than sit in a psychologists’ office.” According to Miller, seeing a therapist may not fit into the paramilitary culture of the police because it indicates weakness and also may not be attractive to the socio-economic class of people who often become officers. Finally, some officers worry about confidentiality and possible threats to their job security (Dowling, 2006; Miller, 2006). In sum, a variety of factors may limit officer help seeking after a traumatic event. For this reason, it could be of practical importance to determine what interventions, processes or therapies would be the most and least attractive to law enforcement personnel. For instance, officers might show similar preferences to previously studied samples (i.e., Angelo et al., 2008; Becker et al., 2007; Tarrier et al., 2006; Zoellner et al., 2003). If officers do show a preference for EBT, this preference (along with the evidence-base) could be used to encourage police department therapists to offer EBT and to design departmental programs and

guidelines for this population. On the other hand, if officers show an aversion to EBT, then a barrier to bringing EBT to police departments becomes better clarified.

The purpose of this study was to extend Becker et al. (2007) by investigating PTSD treatment preferences among active law enforcement personnel, cadets, and students planning to enter the law enforcement field. We included a broad array of law enforcement individuals so as to obtain a moderately large sample that represents some of the breadth in this field. The three subgroups also offer the opportunity to explore on a very preliminary basis if those with real experience with police work have different views than those without such experience.

Becker et al. (2007) examined seven therapeutic options: exposure, a general form of CBT, sertraline (i.e., Zoloft), Eye Movement Desensitization and Reprocessing therapy (EMDR); psychodynamic therapy, and two pseudoscientific therapies (i.e., Thought Field Therapy and My Therapy Buddy). The present study relied on a similar core list: exposure; sertraline, EMDR and psychodynamic therapy. Although EMDR was not well received in previous analog studies (e.g., Becker et al., Tarrier et al., 2006), we included EMDR because it is an EBT that appears popular among therapists, despite significant controversy about its mechanism of action. In this study, we modified the general CBT description in Becker et al. to instead describe Cognitive Processing Therapy (CPT; Resick & Schnicke, 1992; Resick, Nishith, Weaver, Astin, & Feuer, 2002), one of the specific, well-studied efficacious forms of CBT for PTSD. We did this in order to a) examine if there was any preference differences for two of the most well-studied forms of CBT for PTSD (i.e., exposure and CPT), and b) because agencies such as police departments may find it easier to bring in trainers for specific forms of CBT should they choose to adopt such interventions. In addition to changing the CBT intervention, we dropped the two pseudoscientific treatments used in Becker et al. because we wanted to explore officer attitudes about other options that are discussed in the police/trauma literature. Given that participants received no compensation for participation, we felt it prudent to reduce participant burden as much as

possible. The added options included Brief Eclectic Psychotherapy (BEP) and Critical Incident Stress Debriefing (CISD).

BEP combines components of cognitive-behavioral and psychodynamic therapy to form a brief, eclectic treatment for traumatic symptoms (Gersons, Carlier, Lamberts, & van der Kolk, 2000). BEP has been recommended as useful for police officers (Lindauer et al., 2005), and one trial found it superior to waitlist in officers seeking treatment for PTSD (Gersons et al., 2000). CISD is an intervention requiring only one or two sessions of debriefing shortly after a traumatic event. The goal of CISD is to prevent the emergence of full-blown psychopathology; it typically is based in group work run with high-risk occupational groups, although individual debriefing sessions may be used (Adler et al., 2008; Devilly, Gist, & Cotton, 2006). Use of CISD is widespread (Devilly et al.; Gist & Devilly, 2002) and CISD is popular with the law enforcement community (Miller, 2006). CISD includes reconstructing, venting, and normalizing the traumatic event along with some psychoeducation. Adler et al. (2008, p. 253) suggest that CISD is attractive to organizations (e.g., military and paramilitary) because it is sensitive to work cultures, uses peer processes, and is viewed as providing an opportunity for organization members to share their responses to traumatic events. CISD also may be viewed by some as meeting organizational duty of care requirements (Devilly et al.). Finally, because CISD is an immediate and often mandated group intervention, it may not share the perceived stigma of later occurring psychotherapies. Despite these potentially positive features and the ongoing extensive use of CISD, however, research support for this intervention remains limited and troubling. Much of the supporting research suffers major methodological problems (Devilly et al.), and a recent meta-analysis found that CISD did not improve outcome following a traumatic event (van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002). Finally, one of the most recent well controlled studies of CISD among US peacekeepers did not support its use (Adler et al., 2008). Secondary to the problematic research base, researchers, practitioners, consensus panels, and evidence-based guidelines have cautioned that use of CISD be limited or viewed as

contraindicated (Gist & Devilly, 2002). Unfortunately, these recommendations have not been followed given that, as noted above, CISD remains widely used (Gist & Devilly).

Based on the past analog studies discussed above, we hypothesized that individuals in law enforcement would show a preference for exposure and CPT over other interventions such as medication, psychodynamic therapy and BEP. Given low preference ratings for EMDR in two previous studies (Becker et al., 2007; Tarrier et al., 2006) we hypothesized that participants would show little interest in EMDR despite the fact that it has received empirical scrutiny and support (Rothbaum, Astin, & Marsteller, 2005). Our research design focused on having officers respond to a scenario situation in which they developed PTSD. Because CISD is not a treatment for PTSD but rather an intervention designed to prevent later onset of psychopathology, we could not directly compare this intervention with the others in terms of treatment preferences. We did hypothesize, however, that participants would respond at least somewhat favorably to the general rationale for CISD given its popularity. Because we are not aware of any literature that would lead to predictions about differences between law enforcement students, cadets, and active duty officers, we made no hypotheses about these groups aside from hypothesizing a greater number of Criterion A events for active duty officers, secondary to their time in the field. We also planned to collapse the data if we found no significant evidence of differences in these sub-groups.

## 1.2 Method

### *1.2.1 Participants*

The sample for this study ($N = 379$) comprised 99 criminal justice (CJ) students enrolled in a university located in the southeastern section of the United States, 108 cadets recruited from the police department of a large southwestern city, 156 active duty law enforcement officers (e.g., hostage negotiators, park police, detective, patrolpersons etc.) from the same large southwestern city, 12 law enforcement officers from a small city in the midwest, and 4 police officers from a small university campus. The study was approved by the Trinity University

Institutional Review Board and, as needed, appropriate agencies/individuals (e.g., chief of police). Seventy-one percent of the participants were male, and 29% were female. Fifty one percent of participants reported Caucasian ethnicity, 38% Latino/Hispanic, and 10% African American. Regarding educational status, 65% of participants had completed some college or held an Associates degree and 23% had completed their Bachelors degree or beyond. The mean age was 32.00 (SD = 10.36).

*1.2.2 Materials*

1.2.2.1 *Treatment Descriptions*. Descriptions included background and efficacy information along with procedures, usual duration, and possible side effects for each of six main treatment options plus CISD. We sought to offer participants a choice of treatment interventions that varied both in terms of orientation (e.g., cognitive behavioral, psychodynamic, pharmacologic) and the degree of empirical support, so as to represent the range of treatment options that law enforcement individuals with PTSD might encounter. Treatment options included three treatments with robust empirical support, two of which were psychological (exposure therapy and CPT) and one of which was pharmacological (sertraline). As in Becker et al. (2007), we also included two forms of psychotherapy that appear popular among therapists despite being somewhat controversial regarding mechanism of action and/or having less empirical support than exposure and CPT (i.e., EMDR and psychodynamic psychotherapy).We also included one treatment (e.g., BEP) that appears to be gaining some popularity among clinicians who treat law enforcement officers (Lindauer et al., 2005). As noted above, because of the popularity of CISD, we asked participants to comment on CIDS after ranking their main treatment choices. Because CISD is delivered after a traumatic event, but before someone develops PTSD, it was not appropriate to include it with the treatment options for PTSD.

Treatment descriptions were modified from the ones used in Becker et al. (2007) and were constructed to reflect actual information that might be presented to an individual seeking treatment for PTSD. Based on feedback from colleagues who work with this population,

modifications were made to make the descriptions easier to read. Aside from these changes, four of the treatment descriptions were identical to those used in Becker et al. (exposure, sertraline, EMDR, and psychodynamic). The exposure and sertraline descriptions also were used by Zoellner et al. (2003). We modified the CBT description used in Becker et al. to make it consistent with a more purely CPT approach. The descriptions for BEP and CISD were created to match the other descriptions in length and style, and were based on the existing literature. The CPT treatment description was shared with a colleague with CPT expertise for feedback. We did not send out the other treatment descriptions for review because four of the descriptions had been reviewed for the Becker et al. study, and because we did not have colleagues who were experts in BEP or CISD. These latter two descriptions were sent to several clinicians, however, for feedback and modified accordingly.

We sought to present all therapies as viable treatment options. All psychological descriptions were approximately of similar length, between 192 (sertraline) to 228 (BEP) words. See Appendix A for detailed treatment descriptions along with word counts.

*1.2.2.2 Measures*. As in Becker et al. (2007), we assessed participants' opinions of each treatment using a slightly modified version the Credibility Scale (CS; Addis & Carpenter, 1999), which uses a 1-7 Likert scale ranging from "not at all" to "extremely." Items are summed. This scale assesses the degree to which participants find different treatment descriptions credible. Four of the questions from the CS were unchanged from the original version, with the exception of directing participants to PTSD as opposed to depression. The three modified questions were changed in order to make the questions more straightforward for the participants in this study. We made these changes based on the recommendations of individuals who have extensive experience with this population, and who informed us that participants would appreciate "simple language" that did not appear "too academic." For instance, "How logical does this therapy seem to you?" was changed to "Does this type of therapy make sense to you?" Internal

consistency for the CS was good with alpha coefficients ranging from a low of .91 for CISD to a high of .96 for psychodynamic therapy in the present sample.

Participants also indicated their first and second choices for treatment as well as their first and second choices for treatments that they would most like to avoid. We did not ask participants to rank all treatment options because we figured they would have stronger opinions about treatments they most and least want, in contrast to those that fall in the middle. By doing this, we sought to avoid a tendency to over-interpret middle ranking positions.

We assessed PTSD using the Posttraumatic Stress Diagnostic Scale (PDS; Foa, Cashman, Jaycox, & Perry, 1997). The PDS has acceptable diagnostic agreement with interview measures of PTSD (Foa et al., 1997), and it had excellent internal consistency in this sample ($\alpha$ = .93 for total symptom severity).

*1.2.3 Procedure*

After a brief verbal introduction to the study, participants were given a study packet containing a written introduction, informed consent forms, an instruction sheet for the study, and a copy of the following trauma scenario:

*On a night shift you go to a call of a suspicious male loitering in the streets of a neighborhood. You arrive on the scene and find a male breaking into a car. You instruct him to stop and show you his hands. However, the suspect turns and runs.*

*You chase him into a dark dead-end ally. The suspect is cornered and turns around, aiming a gun at you. You fire two shots into the suspect's center of mass.*

*The suspect falls to the ground and drops the gun. You approach the suspect and find that you have fatally shot him. You discover the suspect is a fifteen year-old boy.*

*At first, you try to forget about the incident but this doesn't work out well.*

- *After a few months you begin to have nightmares about the incident.*

- *Handling your gun becomes very difficult because you feel anxious and have flashbacks to the shooting.*
- *You don't want to go to work and once there you often find yourself avoiding the area of the shooting.*
- *Your relationship with your wife and kids has become more difficult.*
- *Recently, you nearly struck your wife when she woke you up suddenly from a nightmare.*
- *You find yourself drinking more than usual.*

*These are common symptoms of Posttraumatic Stress Disorder.*

After reading the scenario, participants read each treatment description and immediately completed the associated CS which was printed on the same page as the description. Descriptions were randomly ordered to prevent order effects. After evaluating all six therapies, participants ranked their top and bottom choices for treatment. Next, participants read the CISD description and completed the CS. They then responded to two final CISD questions. First, they indicated to what degree they thought CISD could prevent need for later treatment using the same Likert scale as used in the CS. Second, they indicated whether or not they believe that law enforcement officers should be required to have CISD after a traumatic event. After this, they were asked about the degree to which they saw themselves developing trauma related stress symptoms at some point in the future and if they developed PTSD, how likely it was that they would seek treatment. We included these to get a general sense of the degree to which the sample saw themselves at risk for PTSD and their general willingness to consider treatment options. These questions were rated on a seven point Likert scale (1-7) ranging from "not very likely" to "very likely". Lastly, participants completed the PDS and demographic questions. Because the study packet was designed to be handed out as a stand alone survey, the final page of the packet contained a take away sheet with mental health resources.

## 1.3 Results

*1.3.1 PTSD Diagnoses and Trauma Histories of Participants*

Thirty-six participants (9.5%) met DSM-IV criteria for PTSD as assessed by the PDS (Foa et al., 1997). An additional 182 (48.0%) participants reported experiencing a Criterion A event during their lifetime, but did not meet criteria for PTSD at the time of the study. Primary Criterion A events included serious accidents (19.0% of total sample), physical assault (12.7%), natural disasters (12.1%), sexual assault (9.8%), combat (6.1%), life threatening illness (5.0%), and other traumas (16.5%).

Because it could be argued that active law enforcement officers might have experienced a higher rate of traumatic events, we examined the frequency of PTSD diagnosis and Criterion A events among officers, cadets and students separately. For PTSD diagnosis, rates among CJ students (9.1%), cadets (10.2%), and law enforcement officers (9.3%) were virtually identical. An additional 61% of CJ students reported a lifetime Criterion A event but did not meet PTSD criteria. In contrast to our hypothesis, this compared to 36% of cadets and 48% of active duty officers, a statistically significant difference $\chi^2$ ($N$ = 343) = 13.13, $p$ <.001. Because rates of PTSD were the same among all groups and because a preliminary examination of treatment preferences showed similar outcomes for the sub-groups, we collapsed the sub-groups for all subsequent analyses.

*1.3.2 Most and Least Preferred Two Treatment Choices*

Treatments were not selected equally as the number one preferred choice by participants $\chi^2$ ($N$ =375) = 264.43, $p$ <.0001. Consistent with our hypotheses, CPT and exposure were the most preferred therapies, with 36.9% and 25.9% of participants selecting these treatments, respectively. The remaining therapies were chosen in the following order: psychodynamic therapy, sertraline, BEP and EMDR (see Table 1). The rank order of the therapies remained unchanged for the second choice with the exception that CPT and exposure

changed places (i.e., exposure was the most selected second choice). Combined, 329 (87%) of the participants selected either CPT or exposure as a first or second choice treatment.

To examine the role of trauma history and probable PTSD diagnosis on treatment choice, we examined choice among participants who reported having a Criterion A event and those who met PTSD criteria. Of the 218 participants who reported a Criterion A event (note: this group includes participants with likely PTSD), 39% chose CPT and 21% chose exposure as their top therapy choice. As with the total sample, 87% or 190 of the participants chose either CPT or exposure as a first or second choice. Overall, the ordering of choices remained basically the same as with the total sample.

Thirty-six participants met PTSD criteria. Among this much smaller sample, CPT remained the top choice (39%), though psychodynamic treatment was ranked as the second top choice (25%). Only 11% of individuals with PTSD chose exposure as their top choice. Yet, 53% rated it as either their first or second choice, a percentage quite comparable to the overall sample (see Table 1). Furthermore, 92% of individuals who met likely PTSD criteria rated either exposure or CPT as their first or second choice treatment.

Regarding the participants least preferred therapy choice, we once again found that treatments were not equally selected, $\chi^2$ (N =374) = 340.52, $p$ <.0001. Medication was the most frequently selected least preferred therapy choice (40%) followed by EMDR (28%), BEP (12%), psychodynamic (9%), and exposure and CPT (both 4%). When least and second least choices were combined, 60% and 57% reported wanting to avoid EMDR and medication. Less than 10% of participants selected exposure or CPT as a treatment they wanted least or second least.

*1.3.3 Treatment Rationales*

Mean ratings and standard deviations for the CS for each treatment and CISD are displayed in Table 2. In terms of the main treatment interventions, the three most highly rated were exposure, CPT, and BEP. CISD, however, also was rated highly and was second only to

exposure in terms of CS scores. EMDR and sertraline were the lowest rated interventions. To investigate the degree to which study participants rated the rationales as equal in terms of credibility, we conducted one within subject repeated measures analysis of variance (ANOVA) using CS scores as the dependent variables. We included CISD in this analysis. Because our hypotheses centered largely on exposure and CPT and because paired comparisons between each intervention would have resulted in 21 follow-up tests, we limited post-hoc comparisons to two sets of simple contrasts, the first between exposure and the remaining treatments and the second between CPT and the remaining treatments. To adjust for multiple comparisons (11 in total) we used an adjusted significance level of .005. For the overall repeated measures ANOVA there was a significant within subjects effect, $F$ (6, 2172) = 137.17, $p$ = .0001, partial $\eta^2$ = .28, indicating that participants rated the interventions differently in terms of the perceived credibility of the rationales. Simple contrasts indicated that participants rated exposure more highly than each of the other treatments, including CPT, with the exception of CISD. A second round of contrasts that compared CPT to all interventions except exposure indicated that CPT was rated as significantly more credible than all of the interventions except CISD. There was no significant difference between CPT and CISD, which were rated almost identically.

Analyses of CS scores in participants who reported a Criterion A event showed an identical pattern except that the difference between CPT and exposure was no longer significant. Among the much smaller sample of participants who met self-report criteria for PTSD, exposure only remained significantly better rated than sertraline and EMDR. The same pattern was observed for CPT.

*1.3.4 Additional CISD Questions and Likelihood of Developing PTSD*

At the end of the CISD CS, we asked participants to what degree they believed that CISD could prevent the need for later treatment. The mean rating was 3.80 (*SD* = 1.74) and the median was 4. Closer examination of this question revealed that a minority of participants (18%)

thought this outcome was very likely (i.e., rated a 6 or 7) and a minority thought it was very unlikely (27%). Next we asked whether or not participants thought that law enforcement officers should be required to have CISD after a traumatic event. Even though the description of CISD noted that recent research indicates that CISD may not have any long term effectiveness and even though most participants did not strongly report thinking that CISD would prevent the need for future treatment, 77% of participants said they did think it should be required.

We also asked participants how likely they thought it was that they would develop PTSD symptoms (rated on a 1-7 Likert scale from “not very likely” to “very likely”). The mean score was 3.95 (SD = 1.74). The median and mode were both 4.00. The mean rating for the question asking whether they would seek treatment if they did develop PTSD was 5.05 (SD = 1.57). The median was 5.00 and the mode was 6.00. Only a minority of participants responded to this question, however ($n$ = 111). This was the only question with significant missing data.

### 1.4 Discussion

Although dissemination of EBT for PTSD has been less than satisfactory to date, previous research regarding analog patient preferences for PTSD treatment indicates that patient factors may play a smaller role than expected given that studies have consistently shown a patient preference for EBT for PTSD. Past research was somewhat limited, however, in that most studies were conducted with university samples. The purpose of this study was to examine a predominately non-collegiate sample at high risk for traumatic events. Consistent with our hypotheses, treatments were not selected equally. Law enforcement individuals, comprised of active duty officers, cadets and CJ students, showed a strong preference for EBT for PTSD with 87% of the sample choosing either CPT or exposure as either a first or second choice. This is an important finding because it suggests that if police departments offered both exposure and CPT then officers would not only have access to EBT, they also would have access to treatment modalities that appear preferred. Importantly, this finding held even when

we examined participants who had experienced a Criterion A event as well as those who appeared to meet criteria for PTSD.

Results from this study also indicated that exposure and CPT were the two treatments that were rated as most credible. Comparisons between credibility scores showed that both exposure and CPT were rated as significantly more credible than all other treatments for PTSD (note: this does not include CISD which is not a treatment). The existing police and trauma literature suggests that officers may be reluctant to seek treatment for PTSD. We could find no evidence in the literature, however, that officers are routinely offered EBT such as CPT and exposure. Thus, it is conceivable that providing officers with treatment that both works and is viewed as credible and preferred may increase officers' willingness to seek treatment. Interestingly, after reading through all of the rationales, officers who responded to our question about likelihood of treatment seeking, showed an overall willingness to seek treatment with a mean and median score of 5.00 on a 1-7 Likert scale. Indeed, 46% of those who responded indicated that they were likely or very likely to seek treatment (rating 6 or 7) should they develop PTSD. We also should note, however, that less than 50% of participants responded to this question, and we had no significant missing data problems with any other question. Although it is impossible to know how to interpret missing data, one possible explanation for the low response rate on this question is that many participants were still reluctant to seek treatment but did not want to indicate this on their questionnaire for some reason.

In terms of differences in preferences for CPT versus exposure, we believe that the literature shows no clear pattern. In the present study, for instance, CPT was chosen as the top choice somewhat more than exposure but exposure was chosen just barely more often than CPT for the top two choices. Exposure also was rated as significantly more credible, although the actual magnitude of difference was fairly small. In our opinion, there is little to be gained at this point in trying to compare these two different forms of CBT against one another in terms of palatability. Rather we would argue that it may make sense for police departments to offer both

exposure and CPT to officers needing treatment for PTSD given that our results indicate that this could match the preferences of approximately 90%. Although there is little support for the benefit of treatment matching in outcome, allowing officers some choice in which form of EBT they receive could increase their sense of control over treatment and make treatment seeking more acceptable. This supposition, however, would need to be tested.

After CPT and exposure, participants showed the greatest interest in psychodynamic therapy followed by sertraline. These results are identical to those from our previous analog study of university students even thought the samples were quite different, which may support the generalizability of previous analog studies. BEP and EMDR were the treatments chosen least often as a top choice and they were the forms of psychotherapy participants reported most wanting to avoid. Medication was listed as the least wanted intervention overall. Notably 60% of participants, compared to 57% for medication, selected EMDR as their least or second least choice. This is interesting because the results for EMDR are consistent with those found in Becker et al. (2007) and Tarrier et al. (2006). Thus, although EMDR appears popular among therapists, when study participants are given information that should be provided in a thorough informed consent process (i.e., clients are provided with the information they need about all viable treatment procedures and scientific support for these procedures so as to make an informed choice about treatment), EMDR is not selected over less controversial treatments with well established evidence bases. Similarly, although the literature suggests some clinician interest in using BEP to treat PTSD in police officers, this treatment also was not preferred to EBT in our sample. Interestingly, the major qualitative finding of this study was that law enforcement officers and cadets reported being very grateful that someone had finally asked them about their opinions about treatment. Thus, we encourage departments and therapists to seriously consider the preferences shown in this study, particularly given that there is an alignment between preferences and treatments with a strong evidence base.

In addition to investigating opinions about PTSD treatment, we also asked participants to rate the credibility of CISD, to indicate how likely CISD would be to reduce onset of PTSD, and whether CISD should be mandated. The results may provide some insight into why CISD remains popular even though it may not only be ineffective, but also potentially harmful (Lilienfeld, 2007). More specifically, two studies to date have found negative effects when CISD was compared to assessment-only control at longer-term follow-up (Lilienfeld).

In this study, participant responses to the question about CISD's ability to reduce onset of PTSD indicated marked ambivalence about the efficacy of CISD given that the median rating on the 7-point Likert scale was 4.00. Just under 20% of participants thought that CISD was very likely to reduce onset of PTSD and just over 25% thought it was very unlikely to reduce onset. Despite ambivalence about the efficacy of CISD, 77% of participants thought it should be required. We can think of two reasons for this discrepancy. First, CISD is widely used and has appealing features that are unrelated to efficacy (e.g., no stigma if all are required to attend post-trauma; gives appearance of meeting organizational duty of care requirements; conveys to officers that someone cares about them, uses peer-processes, provides screening opportunity). Second, participants rated the rationale for CISD as highly credible. Indeed, it was the only rationale rated as credible as exposure. Thus, the rationale for CISD may be so credible that it overrides evidence showing that it is not effective. Along this line, Lilienfeld (2007) notes that most people who receive CISD believe that it is helpful, even when objective measures show this is not the case. One option for reducing use of CISD may be to find strategies to maintain perceived benefits while eliminating the likely problematic component (i.e., forced debriefing). For instance, we conducted a very informal survey of a small number of police psychologists in major cities in Texas. Results indicated that a number had moved away from debriefing during required "CISD" meetings and instead simply provided supportive psychoeducation.

This study has a several limitations to. First, most participants did not have PTSD, although almost 50% had experienced a Criterion A event. Thus, further research is still needed

with clinical samples. It should be noted, however, that results were largely consistent between the total sample and sub-groups who had experienced a Criterion A event or met criteria for PTSD. Second, it could be argued that responses were biased because some descriptions discussed scientific support to a greater degree than other descriptions. These differences, however, accurately represent what is known about the treatments. Thus, it would be inaccurate to claim that all interventions had the same level of scientific support. Third, because patients likely do not receive a complete listing of the empirical bases of multiple treatments in clinical settings, providing participants with this information in this study may challenge the ecological validity. We would argue, however, that perhaps patients should receive this information as part of a true informed consent process, and that this might create more grass roots interest in EBT. Fourth, although word lengths were roughly similar, they were not identical. Word length, however, did not appear to markedly influence choices. When examining the seven intervention descriptions, the three least chosen treatments had the longest (BEP), the shortest (sertraline), and the middle (EMDR) treatment lengths (i.e., three interventions had more words than EMDR and three had fewer words). The three most selected treatments had the second shortest (exposure), the second longest (CPT), and third longest descriptions (psychodynamic). Furthermore, CPT, psychodynamic therapy and EMDR were within a five word range.

In summary, this study supports previous research showing that exposure and CPT for PTSD may be preferred over interventions with less scientific support or that are associated with greater controversy (e.g., EMDR). This study also provides evidence that law enforcement organizations could benefit from directing greater resources towards offering both CPT and exposure therapy for PTSD, which were collectively preferred by approximately 90% of participants as a first or second choice treatment. Provision of EBT for PTSD to law enforcement officers also may improve the palatability of treatment compared to other therapies that may be more available but less preferred and less efficacious.

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Table 1. Percent of participants who chose each therapy option as most or second most preferred

| | Total Sample (*N* = 379) | | Criterion A (*n* = 218) | | PTSD (*n* = 36) | |
|---|---|---|---|---|---|---|
| | Top Choice (%) | Top 2 (%) | Top Choice (%) | Top 2 (%) | Top Choice (%) | Top 2 (%) |
| CPT | 36.9 | 56.7 | 39.0 | 58.7 | 38.9 | 61.1 |
| Exposure | 25.9 | 58.8 | 20.6 | 59.2 | 11.1 | 52.7 |
| Psychodynamic | 13.2 | 29.0 | 14.2 | 28.9 | 25.0 | 36.1 |
| Sertraline | 9.2 | 21.6 | 10.1 | 19.7 | 8.3 | 19.4 |
| BEP | 9.0 | 20.8 | 10.1 | 22.0 | 13.9 | 27.7 |
| EMDR | 1.8 | 5.8 | 2.3 | 5.0 | 2.8 | 2.8 |

Note: Criterion A = all participants reporting lifetime occurrence of a criterion A event. PTSD = all participants meeting full criteria for PTSD. CPT = Cognitive Processing Therapy. BEP = Brief Eclectic Psychotherapy. EMDR = Eye Movement Desensitization Reprocessing.

Table 2. Mean, standard deviation, range on credibility scale and PDS

| Measure | *M* | *SD* | Range |
|---|---|---|---|
| CS - Exposure | 32.89 | 8.69 | 7-49 |
| CS - CISD | 31.29 | 9.68 | 7-49 |
| CS – CPT | 31.26 | 8.17 | 7-49 |
| CS – BEP | 27.15 | 9.62 | 7-49 |
| CS – Psychodynamic | 26.79 | 10.26 | 7-49 |
| CS – Sertraline | 22.77 | 9.82 | 7-49 |
| CS - EMDR | 18.53 | 9.32 | 7-49 |
| PDS symptom severity[a] | 7.61 | 8.90 | 0-42 |
| PDS diagnosis | 9.50% | N/A | N/A |

*Note*: N = 379. [a] Symptom severity is calculated for those reporting a Criterion A event (*n* = 69). CISD = critical incident stress debriefing. CPT = cognitive processing therapy. BEP = brief eclectic psychotherapy. EMDR = eye movement desensitization reprocessing. CS = Credibility Scale. PDS = Posttraumatic Diagnostic Scale.

# Appendix A

*Cognitive Processing Therapy (219 words):* Cognitive processing therapy (CTP) is a treatment for PTSD. CPT can be done in individual or groups and typically takes 12 sessions. CPT has undergone rigorous scientific evaluation and has been supported by clinical trials. The goal of CPT is for you to "process" emotions and confront your beliefs about the incident and its effects on your life. You want to make sense of your traumatic experience. CPT is a form of cognitive behavioral therapy and is used for many traumatic incident related problems.

Procedures used include:

- You will receive education about traumatic events.
- You also will be asked to write detailed stories of the traumatic event and will read them aloud in session and for homework.
- You will be provided basic education about feelings and given information about how self-statements or thoughts affect how you feel
- You will learn how to identify 'stuck points' (troubling emotions from the traumatic event)
- You will learn to challenge incorrect beliefs about the traumatic event such as self blame.
- You will find and maintain a balanced, realistic perception of the world.

If you choose CPT, you will complete weekly 90-minute individual therapy sessions. You will not receive medication for your PTSD symptoms. Side effects of CPT include uncomfortable feeling and unsettling thoughts when remembering the trauma.

*Medication treatment- Zoloft (192 words):* Antidepressants medications are one of the available treatments for PTSD. Zoloft (Setraline) has undergone some of the most rigorous scientific evaluation; it is the only FDA approved medication for the treatment of PTSD. Zoloft is a type of

antidepressant called a selective serotonin reuptake inhibitor. It has fewer side effects than older medicines used to treat PTSD.

In this treatment:

- You do not talk a great deal about your traumatic experience or be asked to confront situations or places you are avoiding.
- You see a psychiatrist weekly for general encouragement and to check out how the medication is working and look for side effects
- Your medication will be adjusted if need be after examination.
- At the end of 10 weeks, the medication will be reduced gradually to minimize the chance of withdrawal symptoms.

If you choose this medicine, you will take up to 200 mg of Zoloft on a daily basis for 10 weeks. The risks from Zoloft are mild to moderate side effects or withdrawal symptoms. Possible side-effects include loose stools, sweating, nausea, headache, fatigue, anorexia, weight loss or gain, sexual impairment, increased anxiety, restlessness, and insomnia.

*Brief Eclectic Psychotherapy (228 words):* Brief Eclectic Psychotherapy (BEP) is a newer therapy used for traumatic symptoms. It uses different scientifically-supported treatments that have each been shown to be effective in treating PTSD. BEP combines parts of cognitive-behavioral and psychodynamic therapy to form a brief, more effective way to treat these symptoms. Since BEP is new, it has not been rigorously tested. However, because it uses methods which used in reducing PTSD symptoms, it could be an effective treatment.

This treatment consists of:

- Individual psychotherapy starting with psychological education about the symptoms of PTSD and treatment protocols

- Imagining the memory of the event concentrating on sensory details of the experience
- Writing assignments such a daily diary or writing letters to persons or institutions involved in the trauma
- Learning to understand the fundamental changes in one's life after trauma and developing meaning
- A farewell ritual to fully express any remaining sorrow over the event, realize that you have left the event behind you and have gained control of your life.

Each part of this treatment is designed to allow you to regain control and predictability of your everyday life, and decrease your PTSD symptoms. If you choose this treatment, you will meet with a therapist for one hour a week for 16 weeks. You will not receive medication. Risk for BEP could include limited effectiveness for acute PTSD symptoms.

*Eye Movement Desensitization and Reprocessing (214 words):* Eye Movement Desensitization and Reprocessing (EMDR) is a structured form of psychotherapy that uses ideas from other treatments. Some research supports the use of EMDR. EMDR generally has positive outcomes and may sometimes be used in combination with other therapies. It has you focus on external stimuli, such as a moving visual object, and tells you to remember traumatic incidents. External stimuli may be tapping with each hand or having your therapist move his/her finger back and forth in front of your eyes.

The therapy goes as follows:

- You will think of the most vivid memory of your trauma and a negative idea.
- You will focus on the memory image while moving your eyes back and forth and following the therapist's finger.
- You will be asked to monitor your body's sensations

- You are then instructed to let your mind wander and/or go blank. Next, you will catalogue your mind's activities.
- Next, your therapist will help you identify the next therapy target. You will simultaneously work on increasing positive ideas.

If you choose EMDR, you will meet with a therapist for several sessions. Often, the number of sessions will be quite limited. You will not receive medications. Risks can include mental distress which can cause adverse arousal of the body.

*Exposure Therapy (205 words):* Exposure Therapy (ET) is a 9-12 session individual therapy for PTSD. ET has been shown to be effective in the treatment of PTSD, and has been thoroughly and scientifically tested. Several controlled studies have shown it to significantly reduce PTSD symptoms. ET is a type of cognitive behavioral treatment that targets a number of trauma-related difficulties.

Procedures for this treatment include:

- Education about common reactions to trauma,
- Breathing retraining (relaxation training),
- Prolonged (repeated) exposure to trauma memories,
- Repeated in vivo (i.e. real life) exposure to situations that you are avoiding due to trauma related fear.

In other words, you will be encouraged to confront the traumatic memory by repeatedly telling the story to the therapist and to challenge things in your life that you are avoiding because you are afraid (i.e. driving a car, walking home at night). You will be assigned homework to encourage you to practice in life the things you learn in therapy.

If you choose to receive ET treatment, you will meet with a therapist about once a week for 60-90 minutes. You will not be prescribed any medication. The risks associated with ET are mild to moderate discomfort when exposed to anxiety-provoking images, situations, and places.

*Psychodynamic Therapy (216 words):* Psychodynamic therapy has been used for over a 100 years to treat traumatic symptoms. The goal is to what understand what happened in the traumatic event and any hidden memories. You want to make sense of defensive psychological processes that allow your unconscious and repressed memories to cause pathological symptoms. Psychodynamic therapy generally has not been rigorously evaluated in research trials because treatment tends to focus on psychological processes as opposed to people's symptoms.

The therapeutic relationship is a critical component of therapy. The goals and procedures are:

- To help you learn how to manage your intense emotions.
- You also will work to achieve a balance between your subjective needs, the external demands of the world, and your traumatic memories.
- Your therapist generally will maintain a neutral attitude during therapy and will not give you advice regarding what to do.
- Instead, will explore you feelings and behaviors so that you can gain insight about your symptoms.

If you chose psychodynamic psychotherapy, you will meet individually with a therapist who will help you work through your underlying issues so that you are able to understand the meaning of your unconscious processes. Treatment may be long term. You will not receive medication for your PTSD symptoms. Side effects may include uncomfortable and unsettling thoughts.

*Critical Incident Stress Debriefing (207 words):* Critical Incident Stress Debriefing (CISD) is a treatment requiring only one or two intervention sessions of debriefing right after a traumatic event. A debriefing process lets the person involved with the traumatic event process and understand the incident's impact. CISD is defusing which allows the discussion of thoughts and emotions from the traumatic incident (called defusing). CISD typically occurs as soon as possible following the incident but no longer than 24-72 hours after the event. Supporters of CISD say that people who receive CISD within this 24-72 hour time period have reduced short-term and long-term crisis reactions or psychological trauma. Recent research, however, has shown that CISD may not have long-term effectiveness.

In the CISD intervention session:

- You will discuss the impact of the traumatic event
- You will also discuss the thoughts, emotions, and feelings surrounding the occurrence as well as possible future reactions
- Finally, you will be asked to attempt to bring closure to the event and discuss ways to move forward

If you choose this intervention method, you will receive a one time debriefing/defusing session immediately following the shooting. You will not receive medication. There are few documented side effects of CISD. However, there are some reports of increased stress after CISD.