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Behavioral Health Training for Police Officers: A Prevention Program

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In 2018, shortly after 2:00 p.m. on Valentine's Day, a lone gunman entered Marjory Stoneman Douglas High School in Parkland, Florida. Once inside, the perpetrator—a former student at the school—began shooting at fleeing students and staff members, killing 17 and injuring 14 others. In response, approximately 50 police officers entered the building to locate and neutralize the subject and provide first aid to the injured where possible.

Throughout the event, emergency dispatchers fielded calls from frantic students, panic-stricken parents, and frenzied staff. This proved the deadliest school shooting since the Sandy Hook Elementary School massacre in 2012.

That evening, local media outlets covering the incident repeatedly advised that all of the school's students and staff members would receive crisis counseling. However, they made no mention of the availability—or need—of any such assistance for the numerous police officers and other first responders directly involved.

Many possible reasons could explain why the care and wellness of police officers, as well as fire rescue personnel and emergency dispatchers, often are considered as an afterthought, if at all. For instance, the public generally believes that these professionals simply perform their expected duties and that they have become desensitized due to their frequent exposure to critical incidents—referred to by psychologists as "traumas." In fact, many law enforcement administrators may feel that such is the nature of police work and that officers must pull themselves together immediately after a crisis.

Unfortunately, years of research on stress and mental health among police officers yielded troubling findings. There are clear indications that officers risk developing mental and physical health issues due—at least in part—to trauma exposure and certain maladaptive coping strategies still supported by police culture.[1] Problems documented as more prevalent among officers than the general population include depression;[2] alcohol abuse;[3] cardiovascular disease;[4] relationship conflict, such as marital discord and domestic violence;[5] post-traumatic stress disorder (PTSD);[6] and suicide.[7]

Officers with PTSD often encounter coexisting difficulties. For example, law enforcement personnel experienced increased psychological distress and bereavement after the 9/11 attacks, and officers who responded to Hurricane Katrina had elevated levels of coexisting PTSD and depression.[8] Those diagnosed with PTSD also can struggle with anxiety, depression, sleep problems, and substance abuse.[9] Further, a significant relationship apparently exists between PTSD and suicidality among police officers.[10]

These unsettling findings underscore the well-known contention that police work is a high-risk profession. They also highlight the need for an effective, coordinated response from the law enforcement and mental health communities directed toward assessment, prevention, and intervention. To this end, the authors present a valuable effort that can not only help counteract the toxicity of a policing career but also serve as one important component in such a comprehensive effort.

Prevention Program

Behavioral Health Training (BHT) for police officers is a preventive strategy that can 1) increase awareness of specific problems that characterize a subset of law enforcement professionals, 2) provide psychoeducation concerning both risk of and protective factors for possible difficulties, and 3) facilitate efforts to identify problems as early as possible and intervene with personnel before they become resistant to change. It offers agencies an example to follow when collaborating with inside and outside resources to provide needed education and awareness for participating officers.

The authors recommend that BHT should begin at the academy level, followed by inclusion in ongoing mandatory departmental training. Also, repeated presentations would help reduce the stigma of stress- and mental health-related issues, thus facilitating peer awareness and support. Traditionally, police agencies have proven difficult to "infiltrate" for mental health providers desiring to help. A prevention program like BHT, focused on education and increased awareness, serves as a useful and safe starting point.

In the design of BHT, the authors recognized the need to present material in a manner that fits with law enforcement culture. They achieved this in the description of content; presentation style; selection of instructors; inclusion of media (e.g., pictures, videos); and use of an optimistic, upbeat, and relaxed approach throughout. While many topics, such as depression, PTSD, and suicide, are inherently negative in nature, the use of a lighthearted approach proves helpful in eliciting favorable responses from program participants and maintaining their interest.

The 2-hour BHT program resulted from a collaboration between a police agency and the psychology department of a local university. It targets areas deemed important by prior law enforcement research combined with the authors' personal experience as mental health and police professionals. Sessions focus on the most significant issues that characterize too many police officers—stress, depression, substance abuse, sleep problems, anxiety and PTSD, and suicide. In addition, outside resources for additional help are presented.

Stress

BHT initially focuses on stress because of its high correlation with the subsequent areas of concern. Instructors cover the fight-or-flight response, physiological effects of stress, and connections to adverse health outcomes. For example, between 2009 and 2018, job-related illnesses caused 25 percent of officer deaths.[11]

Additionally, this section addresses external and internal stressors related to law enforcement. External stressors include supervisory oversight, antiquated or broken equipment, excessive overtime, frequent rotating shifts, and regular changes in duties. Internal stressors consist of family problems, financial difficulties, and perhaps a second job for additional income—and more time away from home.

Finally, an interactive quiz identifies common misconceptions pertaining to stress, such as its correlation with ulcers, and helps normalize the experience of stress both on the job and at home. Discussions focus on the various manifestations of stress (e.g., physical, psychological, emotional, and behavioral), and a review of positive and negative coping techniques follows. At the end of this section, instructors suggest effective behavioral health interventions, such as breathing exercises, muscle relaxation, social support, and self-care.

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Depression

In this segment, instructors emphasize that depression—as well as other mental health problems—constitutes an illness, not a weakness. They also identify other common myths, such as "depressed people never feel happy" and "only medication can treat depression."

A discussion regarding how the condition manifests in various individuals reveals a wide range of signs, including feelings of guilt, changes in weight, relationship problems, sleep difficulties, irritability, increased substance use, and isolation. Specific risk factors for police officers, such as shift work, a hostile work environment, and mandatory overtime, are delineated.

Instructors explain the impact of depression on officers, relating that it can lead to high rates of absenteeism, friction between colleagues, increased anger outbursts, and relationship conflicts.

Finally, general risk factors for depression (e.g., relationship or financial problems, alcohol use, and personal loss) are reviewed.

Substance Abuse

Researchers have concluded that alcohol consumption among police officers is reinforced by law enforcement culture and, further, that it comprises part of socialization and serves as a way to cope with the stressors of the profession.[12] According to estimates, alcohol use among officers doubles that of civilians.[13]

This section addresses the abuse of alcohol, as well as illicit substances and steroids. After presenting research that documents rates of excessive alcohol use among law enforcement officers—ranging from 25 to 50 percent—instructors describe signs of such abuse.[14] Additionally, a true-or-false quiz helps expose common myths, such as the belief that alcohol kills brain cells.

A discussion of steroid use features a video illustration of such practice among police officers. Instructors present common motivations for use, symptoms (e.g., mania or hypomania, psychosis, and personality changes), and resulting consequences (e.g., acne, baldness, high blood pressure, and abnormal liver function).

Sleep Problems

In this unit, instructors highlight sleep issues within law enforcement—as many as 40 percent of officers meet the criteria for sleep disorders.[15] They discuss both short-term complications (e.g., decreased alertness, memory impairment, occupational injury) and long-term problems (e.g., increased cardiovascular disease, lowered immune system, obesity) related to sleep disturbance.

Educational video clips of sleep-deprived drivers review and illustrate signs of insufficient sleep. Additionally, common myths are discussed and dispelled. These include the beliefs that older persons require less sleep and that snoring is harmless.

Instructors also cover sleep hygiene and offer a list of suggestions—keeping in mind that one technique may not work for every individual—that officers can follow to reduce sleep problems. For instance, officers should restrict the use of the bedroom to sleep and sexual activity, adjust lighting and temperature as necessary, time naps appropriately, reduce caffeine and alcohol use, know when to sleep, and handle nightly awakening properly.

Anxiety and PTSD

For this section, instructors present information regarding excessive stress and anxiety that can occur among police officers, including types of conditions like generalized anxiety disorder and panic disorder. Then, they review signs related to anxiety.

Importantly, instructors also address PTSD. Given their continuous exposure to traumatic events, an estimated 7 to 19 percent of police officers experience symptoms of PTSD, compared with approximately 8 percent of civilians.[16] Often, PTSD coexists with other difficulties addressed by the BHT program, including suicide.

This segment features an in-depth discussion of PTSD, including common signs and symptoms. A video covers the professional and personal impact of PTSD on officers. Finally, instructors talk about recommendations and interventions (e.g., critical incident stress management, referrals to outside professionals) following traumatic incidents and identify resources for help.

Suicide

This topic holds particular importance because police officers commit suicide 69 percent more frequently than civilians. Further, they are two to three times more likely to die by suicide than by on-the-job violence.[17] Instructors present common risk factors, signs, symptoms, and interventions.

Warning signs, such as giving away possessions, exhibiting mood changes, and displaying feelings of hopelessness, receive emphasis to help officers recognize potential problems in themselves or their peers. Officers receive instructions on how to approach colleagues who appear at risk for self-harm. Recommendations include not leaving such individuals alone, listening attentively, asking them directly about suspected suicidality, and notifying others when necessary.

Outside Resources

The final section of BHT provides community-specific and nationwide resources for mental health support. For instance, national telephone lines available 24/7, such as 1-800-SUICIDE and 1-800-273-TALK, offer help to those with suicidal thoughts, plans, or intent. Safe Call Now (https://www.safecallnow.org) represents another useful resource because it is staffed with first responders. Instructors also recommend departmental and local resources to officers who want further mental health assistance or support.

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Collaborative Approach

Based on prior research, as well as their own experience, the authors deem necessary a comprehensive approach to identification, prevention, and intervention geared specifically to the care and wellness of police officers. This requires several elements, of which BHT comprises just one. A continuum of care must cover mental and physical health domains.

This proposed strategy is consistent with current prevention models that include efforts in three categories.

1) *Primary prevention* programs focus on averting problems or psychological disorders from developing. Typically, they are applied to large populations or groups and are psychoeducational in nature. BHT serves as an excellent example where all officers in a police academy or agency receive a program designed to increase knowledge, awareness, and resilience. While not all recipients may be viewed as at-risk, everyone receives the training to help prevent future mental health problems.
2) *Secondary prevention* involves interventions for officers who show early psychological or physical symptoms or difficulties with the intention of averting more serious conditions later. For instance, critical incident stress debriefings or defusings typically follow an unusually traumatic event (e.g., line of duty shooting death, serious injury of an officer, death involving a child). This group strategy includes only officers directly involved with the incident, some of whom perhaps strongly impacted. Another example is the use of peer support/counseling programs geared toward training officers to recognize signs and symptoms and assist coworkers who show indications of psychological distress.[18] Such efforts may help reduce the resistance to and stigma associated with seeking help and improve the ability to reduce burnout from critical incident-related stress.[19]
3) *Tertiary prevention* focuses on persons with already-established psychological problems and involves 1) preventing the worsening of these, 2) restoring individuals to the highest level of functioning possible, and 3) implementing interventions designed to decrease the likelihood of relapse. This involves referrals to a mental health provider (e.g., counselor, psychologist, psychiatrist) experienced in working with such problems, ideally involving police officers.

A best-practice mental health approach with law enforcement must involve efforts in all three prevention categories. Actions illustrative of such a model would be providing BHT (primary prevention); implementing peer support training and critical incident stress management efforts (secondary prevention); and offering referrals to resources like mental health professionals in the community when more intensive intervention becomes necessary (tertiary prevention).

Unfortunately, officers historically have held negative perceptions of mental health professionals, stemming largely from the influence of police culture and the traditional view of them as adversaries, rather than as allies.[20] Consequently, providers must be carefully vetted with regard to a number of factors, most notably their interest and experience working with police officers and their knowledge and understanding of law enforcement.

Successful Intervention

After the incident at Marjory Stoneman Douglas High School and the exposure of officers and dispatchers to extreme trauma, early critical incident intervention became a primary concern for the administrators of responding police agencies. In the afternoon following the shootings, contact was made with a local mental health practitioner and a law enforcement administrator (two of the authors) experienced in critical incident stress management and debriefings as well as BHT.[21]

A team composed of several local police departments' certified critical incident stress debriefers was summoned. The team used a combination of debriefings, crisis counseling, and components of BHT with the officers involved. Through the application of these approaches, psychoeducation regarding risk factors, stress management techniques, and peer support were provided.

Further, open dialogue between the mental health practitioner, personnel trained to assist with crisis response, and officers who responded to the scene focused on addressing the impacted officers' current emotional reactions as well as suggesting strategies for coping in the coming days and months. The interactions with peers helped officers learn about tapping into work and family support systems and becoming intuitive about their own mental health. Additionally, officers were encouraged to seek professional assistance if they began to experience PTSD symptoms.

Through this comprehensive approach, the officers gained a knowledge base to help themselves and their peers, should the need arise. Further, resources in the community were identified for those seeking additional assistance from the mental health community.

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Conclusion

Research clearly indicates that police officers can develop mental and physical health issues because of the traumas they face during their career. An effective, coordinated response from the law enforcement and mental health communities is needed to address the care and wellness needs of these professionals.

Behavioral Health Training is an excellent primary prevention program that agencies can use to build the knowledge, awareness, and resilience of all officers. It addresses several significant issues that can impact personnel after traumatic events. While not all recipients may be viewed as at-risk, everyone receives the training to help prevent future mental health problems.

Secondary prevention efforts, such as critical incident stress management, have become popular in many local, state, and federal law enforcement agencies and serve as another important element. Evidence for peer support training suggests their value as well.

Finally, agencies must employ tertiary prevention measures for officers who have established psychological problems. A list of resources should be available to personnel in the event that a more intensive response (e.g., counseling, therapy, hospitalization) is needed.

Such a comprehensive approach proves necessary to address the mental health problems that can result from this difficult profession.

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