Critical Incident Stress Management (CISM)

Critical Incident Stress Management (CISM), which was first described by Jeffrey Mitchell, PhD (Mitchell,1983), has become so widely deployed and adopted by first responder organizations that its acronym CISM has become synonymous and interchangeable with the concept of psychological wellness in first responder organizations. This conflation of the concept of psychological wellness and the "manualized" intervention of CISM has both granted a great deal of legitimacy to CISM and unfortunately constricted and hindered the development of meaningful psychological wellness programs for first responders. Given that virtually every first responder organization, and even most public institutions, have some sort of CISM team, plan, or mandate, and given that virtually all trainings offered to peer support organizations are CISM trainings, it is completely reasonable to assume that CISM is:

1) Well researched and found to offer great benefits to those who receive it.
2) Widely accepted and endorsed by scientific agencies and governmental bodies.
3) Is highly practical to deploy and widely embraced by frontline first responders.
4) Provides services that decrease the legal liability of institutions who offer CISM due to providing their members with this "best practice" post crisis intervention.

The research presented below indicate that none of the above statements are true. The preponderance of the research shows that CISM offers no benefit and may actually be harmful to recipients. Most governmental and nongovernmental agencies that oversee post disaster responses strongly recommend against the use of CISM. CISM is riddled with practical problems and is widely mistrusted by frontline first responders. Additionally, deploying CISM programs is likely to increase the legal liability of organizations making use of the strategies.

Proponents of CISM frequently claim that there is a large body of research showing consistent positive outcomes. Virtually every article reporting any positive outcomes of CISM/CISD was published in the International Journal of Emergency Mental Health. This journal was a wholly owned subsidiary of the now defunct Chevron Publishing Company of Ellicott City, MD which was founded in 1999 by Mitchell and Everly, the two authors of the CISM manual in order to "promote the growth of CISM." Chevron publishing company produced paperback manuals and books on critical incident stress debriefing related topics authored primarily by Mitchell and Everly.[1]

A Cochrane review of the effectiveness of psychological debriefing revealed that while most studies supporting the effort were generally of poor quality, single-session debriefing neither reduced psychological stress nor prevented the onset of post-traumatic stress disorder (PTSD). The review concluded with the recommendation that compulsory debriefing of victims of trauma should cease (Rose et al. 2002). Later Cochrane reviews further recommended against routine use of psychological debriefing to prevent PTSD (Roberts et al. 2009). Devilly and Cotton (2004) have urged organizations to revise policies to "reflect the current weight of scientific evidence" because there were no reliable

[1] The International Journal of Emergency Mental Health was acquired by OMICS International Journals in 2013. The name was changed to The International Journal of Emergency Mental Health and Human Resilience and is now a free online Journal that no longer publishes articles about CISM.

studies that demonstrated the efficacy of group debriefing and that critical incident stress debriefing/management was ineffective for individuals. Later, Canadian researchers writing in the Canadian Medical Association Journal (Szumilas et al. 2010) reached similar conclusions, concluding that their analysis shows no evidence to support the use of psychological debriefing. Other studies such as Voerman & Gersons (2000) found evidence that police officers who participated in CISD/CISM showed more severe PTSD symptoms at follow-up. Devilly & Cotton's (2003) summation remains as accurate now as it was in 2003, "Current outcome expert consensus and meta-analytic reviews suggest that CISD is possibly noxious, generic psychological debriefing is probably inert and that more emphasis should be placed on screening for, and providing, early intervention to those who go on to develop pathological reactions."

While CISM is still widely disseminated to first responder organizations, many of the world's governmental and non-governmental agencies have issued statements recommending that CISM interventions not be used. These include the World Health Organization, the American Red Cross, the National Institute of Mental Health, The United Kingdoms National Institute for Health and Care Excellence, Harvard University, the University of Rochester, a 2005 NATO-Russia workshop on responses to terrorism, and the InterAgency Board. Table 1 summarizes excerpts of all these organizations' cautionary statements on CISM.

The complete lack of scientific evidence showing positive outcomes from CISM, and some studies suggesting that CISM may actually be harmful, combined with many leading organizations strongly recommending against CISM has led some authors to suggest that organizations deploying CISM may actually be incurring legal liability (Bledsoe, 2003; Devilly & Cotton 2004). While first responder organizations desire to provide support for their personnel, especially in the wake of highly stressful incidents, providing flawed and possibly pathogenic interventions may be worse than no response at all.

Beyond the scientific, institutional, and legal issues with CISM this author's own experience in discussing CISM with law enforcement officers in Western Washington has been that CISM is regarded with mistrust and viewed as distaste for several reasons. First, critical incident stress debriefs (CISD) are run by mental health professionals brought in from the community and are unknown to the officers participating the debrief. As a result, officers are hesitant to discuss the facts of an event, much less their cognitive and emotional responses to it, with an unfamiliar civilian outsider. This hesitance in some officers is based on their concern of having their actions and responses negatively judged as well as a fear they are being evaluated as to their fitness for duty during the debriefing process. Second, the law enforcement culture is not one wherein emotional expressivity, especially for any emotions beyond anger, is normalized or encouraged. Asking a group of law enforcement officers to sit around in a circle and talk about negative emotions in front of their peers runs highly contrary to their social norms. Third, officers have a very real fear, especially in incidents involving a civilian fatality (e.g. officer involved shooting, attended suicide, witnessed accidental death, etc.) that admitting to sadness, regret, guilt, anger, or other negative emotions in front of others, especially outsiders, may increase the likelihood that they will personally experience negative legal consequences. For example, if an officer admits during a CISD that they feel guilt for shooting a suspect, even if the shooting was justified and within policy, officers fear their admission of feeling guilty may be used as evidence in a criminal or civil suit as proof of their legal culpability. Psychologists working with the Los Angeles Police Department (LAPD)and Calgary Police Service observed similar concerns from these agencies' officers. CISD attendance by

officers was zero or minimal, and participation even more minimal when attended (Craw, Behavioral Science Services, LAPD; Ferland, Calgary Police Psychological Services, personal communications 2022).

If Not CISM Then What?

There are two even greater and more fundamental flaws in Critical Incident Stress Management as an approach to officer psychological wellness than those already discussed. These flaws are shared by other, less controversial, approaches such as Psychological First Aid and Peer Support based interventions. These flaws are placing virtually all intervention emphasis on post-critical incident response and focusing solely on single session interventions.

The first fundamental flaw of critical incident focused interventions is that focus all support on only the most high-profile and low frequency events. While critical incidents by their very nature are highly stressful and likely to be traumatic, not only are they not the only acute stressors that law enforcement officers are exposed to, they compose only a small fraction of the overall stressors that law enforcement officers experience. Most potentially traumatic situations encountered by officers do not rise to the level of a "critical incident". Though the term "critical incident" is poorly defined, it is generally viewed as capturing larger, dramatic, and low-frequency events with catastrophic outcomes. While critical incidents, both directly and indirectly experienced, are certainly potentially traumatic, they are not the only potentially traumatic events that law enforcement officers encounter on a regular basis. Accidental child deaths, child sexual abuse, gruesome homicide scenes, physical assaults, etc. would generally not be seen to rise to the level of a "critical incident". Therefore, within the conceptualization of these interventions such incidents would not be addressed. Given the high frequency with which law enforcement officers are likely to encounter these types of potentially traumatic events it would be neither practical nor well advised to mount a large group intervention after each one. However, this does not mean that individual officers may not be greatly negatively affected by such experiences. Additionally, there are a host of other less acute and more chronic stressors that go completely unaddressed by critical incident focus interventions. Research on law enforcement has identified such stressors as unique dangers (Bierie 2017), distinct social stressors from peers and the general public (Adams and Buck 2010), monotony, and scrutiny by the community and media (El Sayed et al. 2019). Chronic exposure to such stressors has been associated with numerous detrimental mental health outcomes including deficits in cognitive abilities (Gutshall et al. 2017), burnout (Kula 2016), psychological distress, and emotional exhaustion (Adams and Buck 2010), and the development of psychological disorders (Syed, Ashwick et al 2020).

In a recent systemic review and metanalysis by Syed, Ashwick, et.al (2020) which included 272,463 police personnel from 24 countries, found that police officers demonstrated psychological disorders at more than doubled the rate of their civilian counterparts. In this large sample police officers met criteria for psychological disorders at the rates of 14.6% for depression, 14.2% for post-traumatic stress disorder, 9.6% for a generalized anxiety disorder, 8.5% for suicidal ideation, 5.0% for alcohol dependence, and 25.7% for hazardous drinking (Syed, Aswick, et al 2020). Similar rates of pathology were seen in a recent sample of 152 law enforcement officers in Texas self-reported: 45% significant sleep disturbances, 32.9% depression, and 12.9% PTSD. In the same sample**,** while 62.8% of officers endorsed symptoms falling above the clinical cutoff for at least one of the conditions studied, <u>only 1.4% of officers were currently in mental health treatment</u> and 17.9% reported that they had previously sought out mental health related treatment at some point in time (Boland & Salami, 2020).

In the face of such high levels of stress, intensity of distress, and high rates of psychopathology why are law enforcement officers so hesitant to engage in mental health services? Most researchers studying law enforcement officers' attitudes toward mental health have focused on officers' interactions with members of the public who present in psychiatric distress, whereas there is less literature on officers' attitudes toward themselves or colleagues with mental disorders. Some previous research has found officers' attitudes toward seeking professional mental health services to be neutral; however, officers also expressed concern regarding how to pragmatically utilize services, for instance not knowing where to access help (Karafa and Tochkov 2013) or not having enough time to access help (Martin et al. 2021). Most studies have found the largest factor to be ongoing stigmatization of accessing mental health services, especially for officers who have mental disorders (e.g. Haugen et al. 2017; Karaffa and Tochkov 2013; White et al. 2016). The culture within policing presents as a challenge hindering officer's comfort to discuss mental health with colleagues and managers, and therefore also in accessing support services (Bell and Eski 2016). A level of distrust of those outside the organization, in addition to officers not wanting to be perceived as weak for inquiring about mental health supports, also perpetuates reluctance in seeking out services (Karafa and Tochkov 2013). Further, fear of confidentiality and how mental health treatment may impact one's career appear to be particularly salient factors related to mental health stigma among law enforcement officers (Haugen et al. 2017).

The second fundamental flaw with current approaches is an emphasis on single session interventions and "quality of life" interventions. It is easy to see why busy and frequently overworked, well-intentioned institutions find much allure in the idea that a single session intervention, such as CISM/CISD, delivered by an outside "expert" on a one-time basis will be the "magic bullet" that addresses the mental health concerns of their personnel. In all the annals of psychological research there has never been a single session intervention that has yielded positive psychological outcomes, and certainly there has never even been a serious attempt to address serious psychological disorders such as PTSD, depression, generalized anxiety disorder, etc. with a single session intervention[2]. Alternatively, many law enforcement organizations are understandably not equipped with the knowledge, skills, and abilities to decrease the stigma in law enforcement culture. These organizations seeking psychological help have veered toward providing quality-of-life programs in the hope of ameliorating the stress officers feel. Such attempts include the use of emotional support animals, encouraging exercise, offering yoga and meditation classes, morale building activities such as team sports, offering classes and groups to teach stress relieving hobbies (e.g. flyfishing), and engaging the services of motivational speakers. Many of these programs and interventions may have merit and attempts to raise overall consciousness of the impacts of psychological stressors and encourage steps to address the stressors. All of these programs may help increase coping mechanisms and have value for increasing morale and enhancing resilience. However, none of these interventions address the complex trauma and severe psychological impacts experienced by law enforcement officers.

What then is the most effective method of addressing mental health concerns of law enforcement officers? Mental health treatment, provided by qualified practitioners is supported by research as an effective method of mitigating mental health symptoms, with the unmet need for

[2] While CISM advocates claim that CSIDs help bring awareness to the participating officers and encourage them to seek help, there is no data to support that officers are more likely to seek support as a result of participating in a CISD. As there are no explicit steps aimed at decreasing the stigma around seeking help built into CISD, it is equally likely the process of the CISD may increase stigma as decrease stigma.

treatment being identified as a public health problem (Kazdin 2017). With the impact of mental health stigmatization being so great that only 17.9% of law enforcement officers endorsing symptoms ever attempt to seek psychological help and only 1.4% currently receive psychological treatment (Boland & Salami, 2020) is a contrast with the civilian population where approximately 43% of those with any mental health condition have sought out services (SAMHSA, 2019). Law enforcement organizations understandably feel stymied at even approaching the task of reducing the stigmatization of psychological services. The Los Angeles Police Department, Calgary Police Services, and the Tacoma Police Department have all successfully established integrated psychology services that are highly utilized by officers and have decreased stigmatization in their organizations.

The Los Angeles Police Department's Behavioral Science Services (BSS) was founded in 1968 with the hire of Dr. Martin Reiser, the first full-time psychologist in a police agency. Today the BSS has expanded to 15 full-time psychologists and additional staff that include alcohol and drug counselors, a dietitian/nutritionist, and additional support staff. The mission of the BSS is to support sworn officers by providing psychotherapy for individuals and couples, support and educational groups, substance abuse counseling, nutritional counseling, managerial counseling and executive coaching, coordinating peer support, operational support including SWAT crisis negotiations, and advising department leadership on matters pertaining to mental health and wellness. The BSS offices are at a city-owned building geographically separate from the police department itself to allow for greater confidentiality of officers accessing services.

The Calgary Police Services Psychological Services Division (CPPSD) was founded in 1978. The CPPSD was based on the LAPD's Behavioral Science Services model with some structural differences, most notably an expanded number of support staff and moving Occupational Health & Safety responsibilities within this division. The CPPSD is housed at a city-owned building separate from police headquarters. CPPSD is made up of a division director, administrative assistants, office coordinator, psychiatric nurse, supervising psychologist, six Masters level therapists, a dedicated peer support team, and other support staff totaling 44 in all. The core care team for officer wellness is made up of eight staff, namely the office coordinator, supervising psychologist, and six master's level therapists. CPPSD therapists engage in many of the same activities described above namely: Rapport Building, Psychotherapy, Education, Peer Support Supervision, and Consultation. The CPPSD also extends services to officers' spouses and children. CPPSD has limited the number of sessions officers can receive to 12 annually, though the therapist can request an additional 12 sessions. Additionally, the CPPSD has instituted an optional but encouraged Health Check program. One week each month CPPSD therapists schedule no regular sessions but makes themselves available for short notice or "drop-in" appointments. Officers are strongly encouraged to avail themselves of these Health Check services and receive at least an annual psychological assessment. Officers in higher stress specialty assignments (e.g. sex crimes, SWAT, undercover, etc.) are especially encouraged to check in regularly and as needed.

The Tacoma Police Department (TPD) contracted a clinical psychologist[3] in March 2018 following the on-duty shooting and death of an officer 18 months earlier, to serve in a newly created department psychologist position. Unlike the BSS and CPPSD, this is a contract position rather than a full-time salaried employee. This department psychologist maintains his own offices separate from the police

[3] The current writer, Neil M. Kirkpatrick, Ph.D. is the department psychologist for TPD. The position was initially proposed in October of 2017, and implemented in March of 2018.

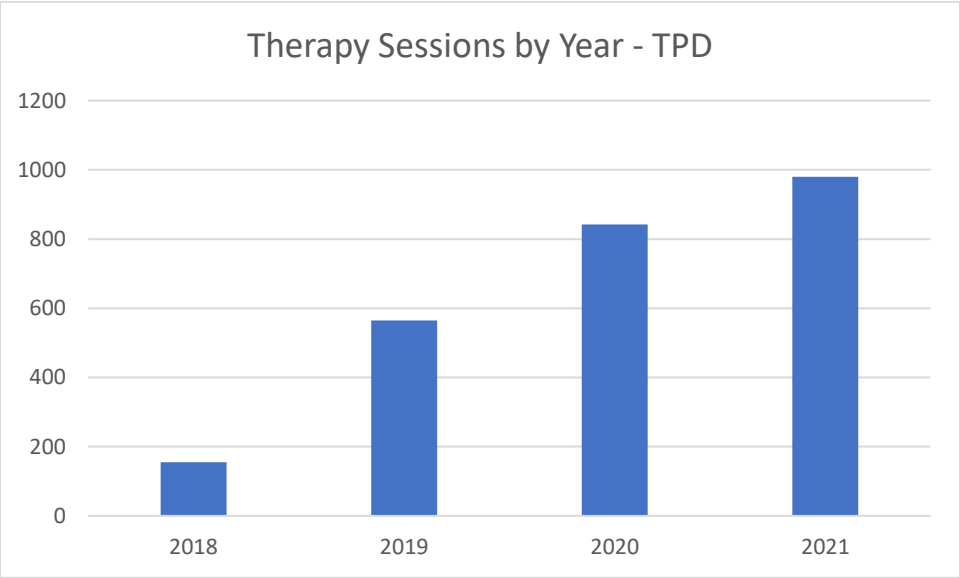
department. Though both the TPD and the contracted psychologist were unaware of either Los Angeles or Calgary's programs, the TPD position has evolved along similar lines. This department psychologist serves many of the same functions as BSS and CPPSD including Rapport Building, Psychotherapy, Education, Peer Support Supervision, and Consultation. In addition, the TPD department psychologist has also worked with the training division to develop and/or rewrite sections of the Police Training Officer (PTO) program.

The best program in the world is of no use if officers do not avail themselves of it. The lack of acceptance and utilization by officers that has been a chronic problem with other attempts to increase officers' psychological wellness. Given that stigma has been identified as the greatest barrier to seeking mental health services for officers, the number of officers seeking therapy services and the total number of therapy hours delivered would be good indicators of successfully decreasing the stigma in a department. The table below presents the utilization data for the year 2020 for LA, Calgary, and Tacoma.

Site	Psychology Staff	Department Size (Officers)	Therapy Sessions	Individuals Seen	Avg. Session/Officer
LAPD	15	10,000	5,762	700	8.2
Calgary	6	3,000	1,914	169	11.3
Tacoma	1	400	842.5	78	10.8

Stated in another way, 7% of LAPD officers, 5.6% of Calgary officers, and 19.5% of Tacoma officers received psychological treatment in 2020, as opposed to the 1.4% of officers seen in another sample (Boland & Salami, 2020). In discussion with the heads of these programs, all have described a significant year by year decrease in stigmatization of receiving mental health services in their departments as the presence and utilization of department psychologists have become more normalized within their departments. This progression is demonstrated by the yearly totals of therapy sessions in the Tacoma Police Department (Figure 1).

Figure 1



The experiences of psychologists in all three departments have been remarkably similar. Upon first starting at their agencies psychologists are initially met with a fairly high degree of wariness and skepticism. As the psychologists become known faces, demonstrate their value and expertise through presenting trainings and delivering consultation, and directly build relationships with officers during observation rides and informal conversations after roll call/turnouts, officers begin self-referring for psychological services. After the initial wave of early adopters have experienced benefit from receiving psychological services, they begin encouraging peers to also avail themselves of the services provided by the department psychologists. As the usage of department psychologists increase and becomes more normalized, department wide stigma decreases. Therefore, seeking psychological support comes to be seen in the same light as seeking physical therapy after injuring a muscle on the job. In short, rather than accomplishing the probably impossible task of decreasing law enforcement officer's suspicion and avoidance of outsiders, psychological treatment providers become "insiders" as they as are integrated into the departments. Approaches to officer psychological wellness that focus solely on bringing in a single outside expert post critical incidents and training peer support officers to support post-critical incident debriefing's is akin to replacing the entire medical system with volunteer staffed first aid tents that are open four times a year. In contrast, embedding psychologists within the department is akin to setting up an on-site medical clinic that is open year-round.

Guidelines for Establishing Department Integrated Psychological Services

There is no one-size-fits-all approach to integrating psychological services within a law enforcement organization. Law enforcement agencies vary widely in the number of officers, geographic disbursement, mission, and culture. In looking at the programs in Los Angeles, Calgary, and Tacoma we see a great deal of variation in how these programs are structured and staffed. In order to define the role of Department Psychologist and set practical guidelines for how a department might go about establishing a department integrated psychological service, it is necessary to identify the essential and optional functions the service may provide. An assessment of the factors that help determine the service staffing-level and structure needs are then considered. Below are a few possible examples of ways a department integrated psychological service could be established and structured to meet different departmental needs.

Essential functions of Department Integrated Psychological Service

1) **Psychotherapy**: The single most important function of a department psychologist is to provide mental health support and psychological treatment to agency sworn officers. Officers are understandably concerned that the very act of seeking treatment may be used against them either administratively or in legal proceedings. The level of confidentiality must be no different, and in some ways, greater than if the officers were seeing a therapist in the community. For example, officers do not directly pay for services, and therefore do not process claims, which include a diagnosis and treatment dates, through their insurance carrier. Therefore, not only what is discussed in treatment sessions is held confidential but the very fact of an officer's participation in receiving services is also held confidential. In simple terms, while an agency may receive information about how the department psychologist is spending their time (e.g. psychotherapy, training, rapport building, etc.) the agency will not have access to records or knowledge of which officers are participating in treatment. Since 2016, licensed psychologists in

the state of Washington have enjoyed the same level of confidentiality as attorney-client privilege (RCW 18.83.110). Masters level therapists, who have a more diverse range of educational backgrounds and licensure types (e.g. LICSW, LMHP, LMFT, etc.) are also given a high level of privilege communication by law (RCW 5.60.060). Whether this is equivalent to the level of confidentiality granted to psychologists is a legal question beyond the scope of this writing.

The mental health needs of law enforcement officers are diverse and extend beyond posttraumatic stress disorder to include evidence-based assessment and treatment for a wide range of symptoms and disorders including complex trauma, suicidality, depression, substance abuse, couples therapy, and more. While Calgary extends this service to family members of sworn officers, doing so does create some other issues such as decreased therapist availability and the possible need to terminate treatment with family members in the case of divorce or officers' separation from service. In part, Calgary offsets the potential for these issues by limiting the number of yearly sessions to 12 per officer. Therapists may request an additional 12 sessions within the same calendar year. Los Angeles and Tacoma restrict services to sworn officers and staff, though couples and family therapy are offered if the officers are participating, and do not limit the number of sessions.

2) **Rapport Building**: To effectively function within an agency and carry out their other functions, department psychologists must maintain a visible presence within the agency. While some of the other roles that a department psychologist will engage in may also serve a rapport building function (e.g. training, group support, etc.) it is critical that they also engage in informal rapport building activities such as semi-regularly attending roll call/turnouts, sporadic observation rides, attending department social functions, etc. Such activities allow officers to gain an interpersonal sense of the department psychologists, help the department psychologist to build relationships with officers/staff, and serve to build a sense that the department psychologist is part of the department's culture. Many, if not most, officers who schedule assessment or therapy sessions do so during such informal interactions. Such informal interactions also allow for the psychologist to identify pertinent training topics, monitor department morale, and provide impromptu consultations with officers and supervisors.

3) **Education**: Law enforcement agencies frequently contract with outside trainers to provide education on a wide variety of topics related to officer wellness and mental health. The efficacy of these trainings is frequently questionable due to many of the same issues that interfere with officers seeking mental health treatment. Officers are frequently suspicious of outsiders, there is a large culture gap between mental health providers and law enforcement, trainers deliver their training on a one-time basis and are no longer available for clarification to address follow-up questions, and officers frequently experience these trainings as "off the mark" in terms of the content relevance to their day-to-day functioning. Once embedded, department psychologists have the advantage of "speaking the language", already established their expertise with the officers they are training, and the ability to tailor the trainings to the specific needs and culture of specific subdivisions of the department (e.g. SWAT, Sex Crimes, Patrol, etc.). Being embedded

within the department enables the psychologists to be available for follow-up questions and clarifications on an ongoing basis (including repeating the trainings as needed).

Department psychologists in the three agencies also present brief 10 to 15 minute "mini trainings" from time to time during roll call/turnouts. Additionally, these department psychologists provide the service of vetting prospective outside trainers to ensure competency in their topic areas which will be discussed further in another section. In both Los Angeles and Tacoma, department psychologists deliver pre-Academy trainings to new recruits. Department psychologists in Los Angeles conduct many of the mental health classes and officer wellness classes at the officers' training academy. Los Angeles and Calgary have expanded their services to include a nutritionist nurse and trainings on nutrition and physical wellness.

4) **Peer Support**: In Los Angeles, Calgary, and Tacoma department psychologists play an integral role with the peer support cadre though each department structures these roles differently while serving similar functions. In all cases, department psychologists provide training and clinical oversight to peer support officers. In Los Angeles, department psychologists also provide clinical supervision to a small cadre of peer support officers who are also drug and alcohol counselors. In Calgary, the psychological services division provides both administrative and clinical oversight to a small cadre of dedicated peer support officers. In Tacoma, the department psychologist provides training, clinical consultation, and some degree of supervision on a more informal basis to the peer support cadre.

5) **Consultation:** This category encompasses a wide variety of roles served by department psychologists. Department psychologists advise agency administrators on matters pertaining to officers' mental health including but not limited to: evaluating prospective interventions designed to improved officer wellness, vetting potential outside trainers to ensure their competence and credentials, advising about the impact of policy changes have on officer morale, and providing executive coaching for newly promoted supervisors and administrators. Department psychologists also provide consultation and advice on specific cases and specialty teams that deal with mental health related issues (e.g. homeless outreach teams, sex crimes, etc.). In Los Angeles, with a staff of 15 department psychologists, the role of consultation has been semi-formalized with each division, subdivision, and specialty team assigned a specific psychologist to serve as a consultant on matters pertaining to officer wellness, morale, and mental health related aspects of their missions.

<u>Optional functions of the Department Integrated Psychological Service</u>

1) **Health Checks**: In Calgary, the Psychological Services Division has instituted an "annual mental health checkup" program where officers are strongly encouraged to engage in at least a once yearly checkup appointment with one of their mental health providers. In at least one other agency this writer is aware of, the department has contracted with an outside provider for their sex crimes unit, after being identified as a high stress/high burnout unit, and mandated a one hour annual check-in. Though this program faced initial resistance, once the detectives met once face-to-face with this outside psychologist, a fairly high percentage of them continued with multiple sessions to deal with stress and trauma reactions.

2) **SWAT crisis negotiator team**: In Los Angeles, on a rotational basis, the designated on-call police psychologist responds to any SWAT incident involving a barricaded suspect or hostage negotiation. The psychologist do not serve as hostage negotiators directly. The psychologist's role in crisis negotiations ranges from evaluating the mood and behavior of the subject, recommending negotiation strategies, monitoring the team's stress, monitoring stress in the subject, and consulting with command staff regarding the variables involved and the progress of negotiations. Neither Calgary nor Tacoma psychologists engage in this function at the current time.

<u>Functions that must NOT be served by department integrated psychological service</u>

1) **Fitness for Duty Evaluations**: None of the three integrated psychological services described perform fitness for duty evaluations which are generally required after an officer involved shooting before an officer can return to work. Fitness for duty evaluations run contrary to the role of the department psychologist. Officers are extremely unlikely to seek treatment from or confide in somebody who at a later date may be evaluating their readiness and capacity to do their job. As a result, the function of performing fitness for duty evaluations must remain the role of a psychologist in the community who is disconnected from the department.
2) **Pre-hire Evaluations:** Similarly to Fitness for Duty Evaluations, pre-hire evaluations also need to remain the role of a psychologist mess that the department. The role of the department psychologist must remain supportive, advisory, and collaborative but never evaluative.

<u>Practical considerations of establishing the integrated department psychology service</u>

1) Psychologists to officer ratio: There is no hard data or body of research to refer to in order to determine the optimal psychologist officer ratio. Anecdotally, amongst the three programs examined in the current discussion, a ratio of 1 full-time psychologist per approximately 350 officers seems to be a manageable ratio, though in more geographically dispersed regions this ratio may be lower, and in larger agencies with multiple providers this ratio may be somewhat higher. Los Angeles at 1 psychologist to 670 officers, and Calgary at 1 provider to 500 officers both report themselves as being understaffed and currently in the process of hiring more providers. Tacoma at 1 psychologist to under 400 officers reports generally running at or slightly over capacity.

2) Employee versus contractor: Department psychologists may be either salaried employees or external contractors for the municipalities they serve. In both Calgary and Los Angeles the integrated psychological services providers are salaried employees while in Tacoma the department psychologist is an independent contractor. Though having the department psychologist as an independent contractor may give the appearance of greater separation from the administration of the agency being served in there is no practical difference in terms of confidentiality or ability to serve essential functions. Larger agencies, such as those with the thousand or more sworn officers, requiring multiple department psychologists will be better served by adopting a model wherein department psychologists are salaried

employees and housed in an off-site city-owned building. This salaried model will allow for greater continuity during staffing turnover, accommodate the need for coordination between the department psychologists, can be more economical for departments in the long room. In contrast, smaller departments will likely find it more practical to adopt a contractor model, especially smaller agencies that may require only one full-time or one part-time apartment psychologist.

3) **Office location:** Though it is essential that department psychologists be seen as integrated members of the agency they serve it is equally important that they are also able to maintain a certain amount of separation. Los Angeles, Calgary, and Tacoma department psychologists all report vastly decreased amounts of stigma related to utilizing psychological services within their departments, with officers frequently feeling comfortable discussing their experiences with department psychologists with their peers. However, there is a vast difference between choosing to disclose engaging the aid of a department psychologist and having to enter and exit the department psychologist offices in view of the rest of the department. Integrated psychological services must maintain offices that are geographically separate from the agencies they serve. This may be in a municipality owned or leased space, such as in the case of a larger agency utilizing a salaried psychologist model, or in a privately leased space in the case of smaller agencies utilizing a contracted psychologist model.

4) **Recruiting and hiring:** In order to be successful, a department psychologist must be competent and qualified in three distinct areas. First, they must have the strength of conviction, interpersonal expertise, and temperament to integrate with and successfully navigate law enforcement culture. Second, they must possess a high degree of professionalism and professional integrity that will allow them to effectively manage interacting with the same individuals in multiple roles (e.g. therapist, trainer, consultant, etc.). Third, they must be competent subject matter experts in the areas of: delivering evidence-based psychological assessment and treatment; evaluating and vetting prospective programs and department level interventions based on the current body of scientific evidence; developing and delivering accurate and engaging trainings on psychological topics relevant to law enforcement officers; and delivering accurate consultation in applying psychological principles to a variety of programs and topics. While law enforcement officers are likely adequately able to evaluate prospective candidates in terms of social expertise and temperament, they will only be able to partially assess candidates in terms of professionalism and professional integrity (which are different standards than they are for law enforcement), and law enforcement officers are completely lacking in the necessary background and knowledge base to assess candidate psychologists' quality of training and professional competencies. Additionally, when recruiting prospective candidates, while law enforcement officers can describe attributes and outcomes desired from department psychologists, they will not be able to give detailed descriptions of the actual workflow, tasks, and challenges from the perspective of a department psychologist as it is outside of their work experience. For these reasons, law enforcement agencies will need to enlist the aid of established psychologists for assistance with recruitment and interviewing of prospective department psychologists. Ideally, agencies will contract with psychologists

currently working with established integrated psychological service programs such as the programs described n this report. Though enlisting the aid of identified expert psychologists at nearby universities or in the local community (e.g. psychology clinic directors at local hospitals) could also serve as an option. Recruiting qualified providers is likely to be one of the greatest challenges in establishing an integrated psychology service, it is almost one of the most important. Hiring unqualified or less than fully competent providers in officers rejecting not only that provider, but rejecting the very idea of psychological treatment itself if they found their first experience with treatment to be that it was not helpful.

5) **Psychologists and Masters Level Therapists:** As discussed above, an Integrated Psychology Service must serve a wide variety of functions. While it is possible that some of these functions may be equally well served by doctorate and Masters level providers, other functions lie beyond the training received by the majority Masters level providers and/or have the potential to create liability for the agency when performed by Masters level providers. For example adapting evidence-based treatments to the specific needs of a law enforcement population/organization, applying the scientific principles of psychology to specific organizational consultation, and evaluating the scientific evidence and literature supporting potential new interventions or therapies are all areas of training that psychologists receive that Masters level providers do not. For another example, an integrated psychology service will need to perform assessment and diagnosis of a diverse array of disorders and psychological issues such as suicide risk, cognitive impairment, and risk for violence, all types of assessments that carry a potential for liability especially when performed by providers who have not received comprehensive training in those areas. Los Angeles Police Department's Behavioral Science Services is staffed solely with doctorate level providers (i.e. psychologists) for these reasons. In contrast, the Calgary Police Psychological Services employs a single psychologist to fulfill those functions that are beyond Masters level training and provide clinical supervision and oversight for their six Masters level therapists.

<u>Three Models of an Integrated Psychology Service</u>

Washington state has 8,600 sworn officers spread between 260 law enforcement agencies ranging in size from fewer than 10 officers all the way to 1,325 officers in Seattle. Additionally, single agencies personnel may be greatly geographically separated, such as the 1,100 sworn officers of the Washington State Patrol that are spread throughout the state. As a result of this wide disparity in size, location, and mission there is no one-size-fits-all approach to structuring an integrated psychology service. Below we will present three possible models for structuring an integrated psychology service. These are not intended to be exhaustive, rather they are intended to illustrate different ways in which an integrated psychology service could be structured to meet the needs of different agencies.

1) **Agency Psychological Services Unit** - An agency specific integrated psychology services exemplified by the Los Angeles Police Department's Behavioral Science Services. A psychologist serving as the clinical director would hire (with agency personnel involvement), administratively oversee, and clinically supervise a team of department psychologists. The psychologists would be salaried and their offices housed within a city-owned or leased building separate from the police department itself. Administratively the clinical director would report to the chief or

deputy chief of the department. This model is most appropriate for larger departments with 600 or more officers needing two full-time, or one full-time clinical director and multiple part-time department psychologists.

2) "**Metro" Contracted Psychology Service** – There are many geographical areas within Washington state where with many smaller law enforcement agencies. These same areas often have multiple smaller agencies within the same region. For example, in the Olympia area the Thurston County Sheriff's Office has 98 officers and 107 corrections deputies, Lacey Police Department has 40 officers, Tumwater Police Department has 33 officers, Shelton Police Department has 19 officers, Olympia Police Department has 67 officers, and the Yelm Police Department has 15 officers, for a total of 379 sworn officers within a single geographical region. In a case such as this it would be possible to have a single full-time psychologist, or two part-time psychologists in the same office contract with multiple agencies. Though the complexities of negotiating and managing, in this example, six separate contracts would be burdensome and likely to further complicate the already difficult task of recruiting the psychologists and establishing such an integrated psychology service. However, if these agencies were to enter into an agreement with each other, similar to what has already been put in place for sharing funding and resources with K-9 programs, a single contract could be implemented and administered. Similarly, Washington State Patrol barracks which are spread throughout the state, or County Sheriff regional divisions in larger counties, might contract with such "Metro" psychology services that were geographically near to them. In this model, the "Metro" psychologist(s) would provide their own office space and any needed administrative support, though they would need a designated person within each department at the chief or assistant chief level as a point of contact. Additionally, a larger proportion of their time would need to be devoted to rapport and consultation activities as they would be developing relationships within multiple agencies.

3) Solo Contractor/Salaried Psychologist – For departments with 250-400 officers a single department psychologist may fulfill the functions of an integrated psychology service. This psychologist may be either salaried or contracted. This provides advantages of simplicity of contracting/hiring, officers may more quickly become accustomed to a single recognizable individual, and eliminates the need for support staff.

Supporting the Development of Integrated Psychology Service Programs

In summary, while single session and quality-of-life interventions may be highly appealing due to their lower cost, lower logistical demands, and practicality of implementation they fail to address the complex and very real mental health needs of law enforcement officers. In contrast, an integrated psychological service requires a much greater initial and ongoing investment in terms of time, resources, and personnel and has been shown to be an effective method of meeting law enforcement officers acute and ongoing mental health needs. Law enforcement agencies in Washington state, which are already undergoing a staffing crisis of academic epidemic proportions, are unlikely to be able to take on the challenge of establishing an integrated psychology service even if the model were presented to them. Below are presented two ways in which the state might support officers having access to

integrated psychology services, a state-funded Integrated Psychology Services Network and an Integrated Psychology Service Development Team.

Integrated Psychology Services Network

An Integrated Psychology Services Network would be an ongoing program funded by the state and administered through the CJTC. Within this model, and Integrated Psychology Services Network Team (IPSN) would be established at CJTC that would consists of a program director who is a licensed psychologist, an administrative assistant, and two liaisons. This team would then begin a comprehensive survey of each geographical region within the state to determine the size of each agency within that region, the current utilization of contracted and salaried psychologists and masters level providers, and what combination of Agency Psychological Services Unit, Metro Contracted Psychology Service, and Solo Contractor/Salaried Psychologist would best meet the needs of the agencies within that region. The IPSN team would then begin the processes of recruiting and hiring qualified providers and liaising with the law enforcement agencies within the region to introduce the mission, functions, and personnel of local IPSN provider(s). As the IPSN became staffed and established, the IPSN team will provide ongoing supervision administration of the network including but not limited to ongoing clinical supervision, ongoing administrative oversight, recruiting and hiring, and budgetary oversight. Developing, establishing, and fully staffing the Integrated Psychology Services Network would likely take 2 to 4 years, at full staffing levels the expense would be as follows:

Item	Yearly Expense	#	Total
Program Director	$175,000	1	$175,000
Liaison	$94,814	2	$189,628
Travel: Hotel, Per Diem, Overtime	$50,000	3	$150,000
Support Staff	$77,366	1	$77,366
Psychologists (salaried)	$140,000	34-39	$4,760,000 – $5,460,000
Office space for provider	$24,000	34-39	$816,000 - $936,000
Incidentals for providers (Phone, internet, utilities, etc.)	$7,200	34-39	$244,800 – $280,800
		Total Yearly Budget	$6,412,794 – $7,268,794

The above numbers are based are based on the assumption all providers will be psychologists, all psychologists will be salaried, and they will need independent office space provided within their regions. In actuality, the IPSN would likely be staffed with a mix of contracted and salaried positions, some providers would share office space, etc. However, on average 7 million dollars annually is a fair approximation of the operating cost of an Integrated Psychology Services Network in Washington state.

The advantages of this model include a relatively faster creation time, greater resilience to turn over as there will be a centralized network for recruiting and hiring, and with since providers will be working within a single network there will be in the ability to elicit additional support in times of crisis within a given region. The most significant disadvantage of this model is that the IPSN providers would be salaried or contracted by the CJTC rather than the individual agencies. Officers within given agencies, as

well as agencies themselves, frequently regard state agencies with suspicion and distrust. There are many advantages of a law enforcement agency having an integrated psychology service including providers who are familiar with law enforcement culture and workflow, the ability to access services rapidly in time of need, etc. however, the single greatest advantage of an integrated psychology service is its ability to overcome the law enforcement cultural stigma attached to accessing mental health services by making the mental health provider and insider to the agency. Though given time, skilled providers may overcome the hurdle of being seen as an outsider due to being employed at the state rather than the agency level, it will doubtlessly create a significant barrier that would have to be overcome by the individual providers.

Integrated Psychology Service Development Team

An alternate model for disseminating and supporting the development of integrated psychology services within law enforcement agencies would be through the creation of an Integrated Psychology Services Development Team (IPSD) and supporting grants. Similar to the previous model, in this model the state would fund the CJTC to form a team including a psychologist program director, two liaisons, and a support staff who would then begin a comprehensive survey of each geographical region within the state to determine the size of each agency within that region, the current utilization of contracted and salaried psychologists and masters level providers, and what combination of Agency Psychological Services Unit, Metro Contracted Psychology Service, and Solo Contractor/Salaried Psychologist would best meet the needs of the agencies within that region. The IPSD team would then approach the agencies within each region, present the possible and suggested models for forming an integrated psychology service. The IPSD team would then assist the agencies with the tasks of establishing an integrated psychology service including recruiting, vetting, hiring or contracting qualified providers, writing policies, and establishing suitable office spaces as needed. Additionally, the IPSD team would provide sample contracts and creating “metro” agreements between agencies in regions where the “metro” model is the most appropriate model. Within this model the state would then grant the hosting agency funds to pay for the integrated psychology service fully for the first year, at 50% for the second year, and a 25% for the third year. The goal of this funding structure is to encourage agencies, via minimizing the required resources in both money and manpower, to initially establish an integrated psychology service and overcome any initial institutional skepticism. Based on the results and other agencies with established integrated psychology services, once the services become an established part of their agency their value will been demonstrated in the hosting agencies will take over funding. The second role of the IPSD team would be to provide initial support, training, and consultation for providers within the fledgling integrated psychology services both directly and by helping them make connections with established programs at other agencies. Within this model the IPSD team would eventually finish the work of establishing Integrated Psychology Services and be disbanded or reduced to a part-time contract for occasional consultation when agencies request assistance with hiring replacement providers or altering ther structure of their programs.

This model comes with several advantages. First, while the initial expense would be similar it would diminish over time as local municipalities took over funding for the programs. Second and most importantly, the “ownership” of the integrated psychology services would rest with the hosting agencies thus allowing the respective programs to serve one of the most essential functions of truly integrating with their agencies and avoiding the additional hurdle of being seen as outsiders due to being

contracted directly with the state. The disadvantages of this model are likely to be a somewhat slower rate of dissemination and less resilience to department psychologist turnover in the future.

Table 1

Organization	Year	Position
American Red Cross	2010	There is no convincing evidence that psychological debriefing or group debriefing are effective in reducing PTSD. CISD/CISM interventions have not been shown to be effective in either eliminating or lessening the development of PTSD and should not be used for rescuers following a potentially traumatizing event. There is evidence that CISD/CISM interventions may have deleterious effects by interfering with normative post-trauma reduction resiliency.
National Institute of Mental Health (NIMH)	2002	Level 1 evidence suggested that early intervention in the form of a single one-on-one recital of events and expression of emotions evoked by a traumatic event (as advocated in some forms of psychological debriefing) does not consistently reduce risks of later developing PTSD or related adjustment difficulties. Further, that such early interventions might place some survivors (e.g., those with high arousal) at heightened risk for adverse outcomes.
World Health Organization (WHO) Department of Mental Health and Substance Abuse	2003 2005 2012	Psychological debriefing should not be used for people exposed recently to a traumatic event as an intervention to reduce the risk of posttraumatic stress, anxiety or depressive symptoms. Strength of recommendation: STRONG
University of Rochester	2006	In light of the former and current research findings, we have chosen not to include critical incident stress management and, particularly critical incident stress debriefing among those approved or suggested early phase interventions
Harvard Mental Health Newsletter	2006	… controlled trials failed to have shown debriefing as being effective but that some studies indicated that debriefing may impede natural recovery.
InterAgency Board (IAB)	2014	There are concerns that those least exposed to significant incident-related trauma may actually experience further trauma during group debriefings. Furthermore, this research did not reveal an appreciable preventative effect. In fact, it suggested that those most severely affected by an incident might have more difficulty resolving their reactions as a result of their participation in these interventions. Authoritative guidelines for early interventions following exposure to traumatic events now recommend against routine debriefing or other procedures incorporating debriefing-like approaches.
UK's National Institute for Health and Care Excellence (NICE)	2018	Evidence on psychologically-focused debriefing, either individually or in groups, showed no benefit for children or adults, and some suggestion of worse outcomes than having no treatment. The committee agreed that psychologically-focused debriefing should not be offered. Providing an ineffective intervention can be regarded as harmful because it means that people are being denied access to another intervention with greater evidence of benefits.

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