Appendix A

NOTE: This bill has been prepared for the signatures of the appropriate legislative officers and the Governor. To determine whether the Governor has signed the bill or taken other action on it, please consult the legislative status sheet, the legislative history, or the Session Laws.

HOUSE BILL 14-1343

BY REPRESENTATIVE(S) Singer and Wright, Exum, Foote, Garcia, Melton, Salazar, Buckner, Fields, Fischer, Ginal, Hullinghorst, Kagan, Lebsock, Lee, May, McCann, Pettersen, Primavera, Rosenthal, Ryden, Schafer, Tyler, Vigil, Williams, Young, Becker, Court, Mitsch Bush;
also SENATOR(S) Tochtrop, Aguilar, Guzman, Heath, Herpin, Johnston, Kerr, King, Newell, Rivera, Schwartz, Todd, Ulibarri, Zenzinger, Carroll.

CONCERNING WORKERS' COMPENSATION COVERAGE FOR POST-TRAUMATIC STRESS DISORDER FOR PEACE OFFICERS.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **add** 29-5-113 as follows:

29-5-113. Peace officers - post-traumatic stress disorder task force - creation - report - repeal. (1) THERE IS HEREBY CREATED THE PEACE OFFICER POST-TRAUMATIC STRESS DISORDER TASK FORCE, REFERRED TO IN THIS SECTION AS THE TASK FORCE. THE TASK FORCE SHALL RESEARCH WORK-RELATED PEACE OFFICER POST-TRAUMATIC STRESS DISORDER AND OTHER RELEVANT TOPICS AS DETERMINED BY THE TASK FORCE AND REPORT FINDINGS AND MAKE RECOMMENDATIONS THAT INCLUDE THE BEST POLICIES AND PRACTICES FOR PUBLIC EMPLOYERS OF PEACE OFFICERS IN COLORADO

_____
Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

CONCERNING IDENTIFICATION, PREVENTION, TREATMENT, COVERED WORKERS' COMPENSATION CLAIMS, STANDARDIZED PREEMPLOYMENT PSYCHOLOGICAL SCREENINGS, AND EDUCATION OF BOTH MANAGEMENT AND EMPLOYEES ON THIS MENTAL HEALTH ILLNESS.

(2) THE TASK FORCE MEMBERS ARE APPOINTED AS FOLLOWS;

(a) THE EXECUTIVE DIRECTOR OF EACH OF THE FOLLOWING DEPARTMENTS SHALL APPOINT MEMBERS AS FOLLOWS:

(I) ONE REPRESENTATIVE FROM THE DIVISION OF WORKERS' COMPENSATION IN THE DEPARTMENT OF LABOR AND EMPLOYMENT;

(II) TWO REPRESENTATIVES FROM THE DEPARTMENT OF PUBLIC SAFETY;

(III) ONE REPRESENTATIVE FROM THE DEPARTMENT OF CORRECTIONS;

(IV) TWO REPRESENTATIVES FROM THE DEPARTMENT OF PERSONNEL AND ADMINISTRATION; AND

(V) ONE REPRESENTATIVE FROM THE DEPARTMENT OF HUMAN SERVICES.

(b) THE PRESIDENT OF THE BOARD OF THE COUNTY SHERIFFS OF COLORADO SHALL APPOINT TWO REPRESENTATIVES OF THE COUNTY SHERIFFS.

(c) THE EXECUTIVE DIRECTOR OF THE BOARD OF THE COLORADO ASSOCIATION OF CHIEFS OF POLICE SHALL APPOINT TWO REPRESENTATIVES OF THE ASSOCIATION.

(d) THE PRESIDENT OF THE COLORADO FRATERNAL ORDER OF POLICE SHALL APPOINT TWO REPRESENTATIVES OF THE ORGANIZATION.

(e) THE PRESIDENT OF THE ASSOCIATION OF COLORADO STATE PATROL PROFESSIONALS SHALL APPOINT ONE MEMBER FROM ITS ORGANIZATION.

(f) THE EXECUTIVE DIRECTOR OF THE COLORADO MUNICIPAL LEAGUE SHALL APPOINT ONE REPRESENTATIVE OF THE MUNICIPAL LEAGUE.

(g) THE EXECUTIVE DIRECTOR OF COLORADO COUNTIES, INCORPORATED SHALL APPOINT ONE REPRESENTATIVE OF COLORADO COUNTIES, INCORPORATED.

(h) THE EXECUTIVE DIRECTOR OF THE COLORADO BAR ASSOCIATION SHALL APPOINT ONE ATTORNEY WITH EXPERTISE AND EXPERIENCE IN WORKERS' COMPENSATION AND EMPLOYMENT LAW.

(i) THE PRESIDENT OF THE COLORADO PSYCHIATRIC SOCIETY SHALL APPOINT A PSYCHIATRIST WHO IS A MEMBER OF THE SOCIETY AND WHOSE PRIMARY AREA OF PRACTICE INCLUDES POST-TRAUMATIC STRESS DISORDER.

(j) THE PRESIDENT OF THE COLORADO PSYCHOLOGICAL ASSOCIATION SHALL APPOINT ONE POLICE PSYCHOLOGIST LICENSED PURSUANT TO PART 3 OF ARTICLE 43 OF TITLE 12, C.R.S., WHOSE PRIMARY AREA OF PRACTICE INCLUDES THE DIAGNOSIS AND TREATMENT OF POST-TRAUMATIC STRESS DISORDER.

(k) THE PRESIDENT OF THE COLORADO POLICE PROTECTIVE ASSOCIATION SHALL APPOINT ONE REPRESENTATIVE OF THE ASSOCIATION.

(3) THE GOVERNOR SHALL APPOINT A TASK FORCE MEMBER WHO IS A REPRESENTATIVE OF AN EXECUTIVE DEPARTMENT TO SERVE AS A CO-CHAIR OF THE TASK FORCE, AND THE TASK FORCE MEMBER APPOINTED BY THE PRESIDENT OF THE FRATERNAL ORDER OF POLICE SHALL SERVE AS A CO-CHAIR OF THE TASK FORCE.

(4) (a) THE TASK FORCE SHALL MEET NO LATER THAN JULY 1, 2014, AND AT LEAST FOUR TIMES THEREAFTER AS NECESSARY TO COMPLETE ITS DUTIES. THE MEETINGS MAY BE HELD IN LOCATIONS OFFERED BY THE ENTITIES REPRESENTED ON THE TASK FORCE.

(b) THE CO-CHAIRS MAY ASSIGN STUDY GROUPS WITHIN THE TASK FORCE TO ASSIST THE TASK FORCE IN ITS DUTIES.

(c) THE MEETINGS OF THE TASK FORCE ARE OPEN TO THE PUBLIC. THE TASK FORCE SHALL GIVE FULL AND TIMELY NOTICE TO THE PUBLIC BY

POSTING A NOTICE OF THE DATE AND TIME OF THE MEETING IN A DESIGNATED PUBLIC PLACE PRIOR TO HOLDING THE MEETING. THE NOTICE MUST INCLUDE SPECIFIC AGENDA INFORMATION WHERE POSSIBLE. THE TASK FORCE MAY ACCEPT REPORTS AND PUBLIC TESTIMONY AND MAY REQUEST OUTSIDE ENTITIES TO PROVIDE TESTIMONY, WRITTEN COMMENTS, AND OTHER RELEVANT DATA TO THE TASK FORCE.

(d) ON OR BEFORE JANUARY 15, 2015, THE TASK FORCE SHALL SUBMIT A WRITTEN REPORT WITH ITS FINDINGS TO THE PUBLIC HEALTH CARE AND HUMAN SERVICES COMMITTEE OF THE HOUSE OF REPRESENTATIVES AND THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE SENATE. A MEMBER OF THE TASK FORCE MAY SUBMIT A DISSENTING OPINION TO THE COMMITTEES WITH THE TASK FORCE REPORT.

(e) LEGISLATIVE COUNCIL AND THE OFFICE OF LEGISLATIVE LEGAL SERVICES SHALL NOT PROVIDE STAFF FOR THE TASK FORCE.

(5) THIS SECTION IS REPEALED, EFFECTIVE DECEMBER 31, 2015.

SECTION 2. Safety clause. The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

_____	_____
Mark Ferrandino	Morgan Carroll
SPEAKER OF THE HOUSE OF REPRESENTATIVES	PRESIDENT OF THE SENATE
_____	_____
Marilyn Eddins	Cindi L. Markwell
CHIEF CLERK OF THE HOUSE OF REPRESENTATIVES	SECRETARY OF THE SENATE

APPROVED_____

_____
John W. Hickenlooper
GOVERNOR OF THE STATE OF COLORADO

Appendix B

Peace Officer PTSD Task Force Meeting Agenda Outline

- Call Meeting to Order
- Pledge of Allegiance
- Roll Call of Task Force Members
- Opening Remarks of Co-Chairs
- Approval Previous Meeting Minutes
- Agenda Revisions
- Submission of Documents
- Action Items Pending Review
- Sub-Committee Reports
- Unfinished Business
- New Business
- Task Force Discussion
- Invited Speakers
- Public Comment
- Set Date of Next Meeting & Adjournment

Appendix B

Peace Officer PTSD Task Force Meeting

June 30, 2014

Attendees:

Colorado Fraternal Order of Police
Sergeant Sean Harper, Longmont PD – Co-Chair
Officer Danny Veith, Denver PD

Department of Public Safety
Deputy Director Karl Wilmes, CBI

County Sheriffs
Sheriff Joseph D. Hoy, Eagle County
Sheriff Jim Crone, Morgan County

Colorado Association of Chiefs of Police
Chief Ken Poncelow – Ft Lupton PD
Chief Tom Wickman – Frisco PD

Association of Colorado State Patrol Professionals
Terry Campbell – ACSPP Legislative Lobbyist
*Alternate – Trooper Bellamann Hee, President ACSPP

Colorado Police Protective Association
Suzette Freidenberger – President CPPA

Colorado Municipal League
Ralph Trenary – Loveland City Council

Colorado Counties, INC
Eric Bergman – CCI Policy and Research Supervisor

Colorado Bar Association
Paul N. Fisher, Attorney – CBA Military & Veterans Liaison

Colorado Psychiatric Society
Deborah Coyle, M.D.

Colorado Psychological Association
John Nicoletti, Ph.D. ABPP

Colorado State Patrol
Lt. Colonel Brenda Leffler

Department of Corrections
Rick Thompkins, Chief of Human Resources

Department of Human Services
Lenya Robinson, Director
Trauma Informed and Integrated Care

Department of Labor and Employment
Dr. Kathryn Mueller, Medical Director
Division of Workers Compensation

Dept. of Personnel and Administration
Markie Davis, Manager
State Office of Risk Management

Jack Wylie – Legislative Liaison

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Opening Remarks

Co- Chair, Sergeant Sean Harper, Longmont P.D. called the meeting to order. Sergeant Harper indicated the meeting will be recorded. Minutes will be transcribed from the recording.

Sergeant Harper reviewed the goals of the legislation HB14-1343, which included that the task force will make recommendations and best practices for peace officers concerning Post Traumatic Stress Disorder (PTSD). Sergeant Harper indicated the proposed legislation in this year's legislative session was intended to make sure that police officers with PTSD get the correct level of care. The Task Force will make recommendations for possible legislation that will protect our law enforcement workers.

The Task Force will make recommendations regarding PTSD as it relates to Identification, Prevention, Treatment, Worker's comp claims, Psychological screenings, Education of management and employees with regard to mental health. The final report will be due to the House Committee of the Health and Human Services Committee of the Senate by January 15, 2015.

Representative Singer was present at the meeting and provided an overview of the proposed legislation in last year's session and a timeline leading to the passage of HB 14-1343. He outlined his goals for the Task Force.

Task Force attendees introduced themselves and spoke to their background, knowledge of PTSD, why they agreed to serve on the task force, their role on the task force, and what they were hoping to accomplish by serving on the task force.

Following introductions the Task Force Sergeant Harper call for a short recess.

Task Force resumed the meeting and addressed Task Force business and protocols for future meetings. The following topics were discussed:

- Adoption of standardized public agenda-The Task Force meetings are public. Agenda's for future meetings will be posted at the Capitol and Sergeant Harper will post through the Fraternal Order of Police (FOP). Task force members may forward minutes and meeting notices.
- Meeting Scheduling-HB14-1343 requires a minimum of four meetings. Sergeant Harper commented that additional meetings may be required. The next meeting will be scheduled on July 31, 2014, at the Capitol.
- Public Meeting Mechanics-Official posting of public meetings will be at the Capitol.
- Rules of Order-Meetings will be conducted in an "informal" manner. Members do not have to rise or received permission from the chair to speak. Members will follow the agenda and limit discussion to the subject of the meetings.
- Staffing of the Task Force-Representative Singer indicated he was attempting to obtain staffing for the administrative tasks associated with the Task Force. He was seeking assistance from graduate students. The issue remained unresolved and open.
- Sub-Committee formation-Formal subcommittees were not formed.
- Sub-Committee reports – none
- Utilization and Scheduling of Expert Testimony-Sergeant Harper suggested that three individuals from the FOP wanted to make presentations before the task force. Sergeant Harper offered to contact speakers to determine if one could present at the next meeting.

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- Final Report tasking and review process-Issue remains open pending the identification of staffing.
- General Discussion-

  There was general discussion on the strategy to attain Task Force goals. Discussion on a phased approach to include education meetings, and discussion of proposed recommendations. Recommendations in final report will be the consensus of the group. Members who cannot reach consensus on the topic will have objectives noted in final report.

  Discussion included the format and topics for the next meeting which will focus on PTSD awareness and education. Dr. John Nicoletti (Task Force Member) will present on the topic of PTSD, Officer Danny Veith (Task Force Member) will present on PTSD from an officers perspective and overall wellness, Jack Wylie (Task Force Member) will present on emerging policies pertaining to PTSD, Markie Davis, Paul Fisher, Dr. Kathryn Mueller will present on Workers Compensation, and how it is addressed at the State of Colorado. Sergeant Harper will invite a speaker from the National FOP.

- Public Comment – there was no public comment.

- Next meeting- The next Task Force meeting will be held at the Capitol at 2:30 P.M. in the House Committee rooms. The room is TBD.

The Task Force meeting was adjourned at approximate 4:45 P.M.

Appendix B

LEGISLATIVE TASK FORCE

Peace Officer PTSD Task Force Public Meeting Agenda

Thursday, July 31, 2014 – 1:00 p.m.
Colorado State Capitol
House Committee Room 0112, Basement
200 E Colfax Ave, Denver, CO 80203

- Call Meeting to Order at 1:00 PM
- Pledge of Allegiance
- Roll Call of Task Force Members
- Opening Remarks of Rep. Jonathan Singer/Co-Chairs
- Approval Previous Meeting Minutes
- Agenda Revisions
- Submission of Documents
- Action Items Pending Review
- Sub-Committee Reports (120 MINUTES)
  - -John Nicolette
  - -Danny Veith
  - -Jack Wylie
  - -Paul Fischer
  - -Markie Davis
- Unfinished Business
- New Business
- Task Force Discussion
- Invited Speakers (90 MINUTES)
  - Brandon Bentley (30 min & 15 min Q&A)
  - Steve Stowers (30 min & 15 min Q&A)
- Public Comment

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- Set Date of Next Meeting & Adjournment

Appendix B

Peace Officer PTSD Task Force Meeting

July 31, 2014

Attendees:

Colorado Fraternal Order of Police
Sergeant Sean Harper, Longmont PD – Co-Chair
Officer Danny Veith, Denver PD

Department of Public Safety
Deputy Director Karl Wilmes, CBI

County Sheriffs
Sheriff Joseph D. Hoy, Eagle County
Sheriff Jim Crone, Morgan County

Colorado Association of Chiefs of Police
Chief Ken Poncelow – Ft Lupton PD
Chief Tom Wickman – Frisco PD

Association of Colorado State Patrol Professionals
Terry Campbell – ACSPP Legislative Lobbyist

Colorado Police Protective Association
Suzette Freidenberger – President CPPA

Colorado Municipal League
Ralph Trenary – Loveland City Council

Colorado Counties, INC
Eric Bergman – CCI Policy and Research Supervisor

Colorado Bar Association
Paul N. Fisher, Attorney – CBA Military & Veterans Liaison

Colorado Psychiatric Society
George Hartlaub, MD

Colorado Psychological Association
John Nicoletti, Ph.D. ABPP

Colorado State Patrol
Lt. Colonel Brenda Leffler

Department of Corrections
Rick Thompkins, Chief of Human Resources

Department of Human Services
Lenya Robinson, Director
Trauma Informed and Integrated Care

Department of Labor and Employment
Dr. Kathryn Mueller, Medical Director
Division of Workers Compensation
Absent

Dept. of Personnel and Administration
Markie Davis, Manager
Jack Wylie – Legislative Liaison

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Meeting called to order by Co-Chair Sean Harper, Longmont P.D. at 1:05 P.M., followed by pledge of allegiance and a roll call of task force members. Dr. Kathryn Mueller was absent.

Opening Remarks -

Co- Chair, Sergeant Sean Harper, offered opening remarks and thanked members for attendance and outlined importance of work on the task force. Sergeant Harper related that the IACP was in contact with him and was interested in the work product of the task force committee for the IACP.

Representative Singer addressed the group and indicated he believed he would be able to arrange for a graduate student from CSU to assist in writing the final committee report.

The minutes were approved from the meeting of June 30, 2014. Co-Chair Karl Wilmes indicated he would record minutes for current meeting. Committee Member Paul Fisher may assist with staff for minutes for upcoming meetings.

There were no agenda revisions and no document submissions. Co-Chair Karl Wilmes, indicated the importance of identifying an individual who would be responsible for drafting the final committee report.

Co-Chair, Sergeant Harper introduced PTSD Committee member Dr. John Nicoletti who made a presentation to the group on traumatic events, critical incidents, traumatic reactions and PTSD. Questions and discussions followed the presentation.

Officer Danny Veith, Denver P.D., presented to the group on overall law enforcement wellness. Questions and discussions followed the presentation.

Task Force member Jack Wylie presented on his legislative research. Jack suggested that with the vast amount of information available a research request to Colorado legislative council may be beneficial for the task force work. Representative Singer said he would make a request for the legislative research on PTSD through legislative council.

Markie Davis followed with a presentation on workers compensation issues in the State of Colorado. Markie outlined some of the current statutory issue pertaining to Workers Compensation. The group followed with some follow-up questions to Markie and representatives from the Colorado Attorney General's office, Mr. Clay Thornton and Ms. Jessica Moran.

Markie suggested that Dr. Mulller make a presentation to the group on Workers Compensation issues. Follow-up discussion included concerning what are the normal expectations of a police officer? What are the scope of normal duties?

A short recess followed.

The Task Force resumed business and was called to order by Co- Chair, Sergeant Sean Harper at approximately 2:55 P.M. Sergeant Harper introduced Brandon Bentley; retired Deputy from the Spartanburg County, SC who shared his story relating to an officer involved shooting incident and his

personal experience following the incident. The events following the incident eventually required him to retire on a disability from the Sheriff's office. His presentation was followed by a presentation by Retired Sergeant Officer Steve Stowers from the Hutchinson, Kansas Police Department. Sergeant Stowers told his story of traumatic events encountered in his career leading to PTSD and his retirement from the Hutchinson Police department

Following the presentation the group engaged in a discussion on PTSD, some thoughts on the current law and the ability to amend the statute. Additional conversation included discussion on prevention, intervention, and treatment of PTSD along with peer support groups. Dr. Nicoletti summarized the peer support group legislation for Colorado.

Training was discussed for CEO's to be placed in legislation. Ralph Trenary also asked if Colorado POST could assist with training requirements and awareness for officers.

The Task Force will make recommendations regarding PTSD as it relates to Identification, Prevention, Treatment, Worker's comp claims, Psychological screenings, Education of management and employees with regard to mental health.

- Public Comment – there was no public comment.

Karl discussed next steps. The group will be responsible for individually submitted any ideas for next meeting initial ideas for report. Sean will forward the original legislative bill to the committee and the committee can review and forward thoughts and concerns back to the committee chairs. The committee would then have a base of what language could be agreed too and what language needs work.

- Next meeting- The next Task Force meeting will be held at the Capitol at 1:00 P.M. on August 14, 2014, in the House Committee rooms. The room is TBD.

The Task Force meeting was adjourned at approximate 5:15 P.M.

Appendix B

LEGISLATIVE TASK FORCE

Peace Officer PTSD Task Force Public Meeting Agenda

Thursday, August 14, 2014 – 1:00 p.m.
Colorado State Capitol
House Committee Room 0112, Basement
200 E Colfax Ave, Denver, CO 80203

- Call Meeting to Order - 1:00 P.M.
- Pledge of Allegiance
- Roll Call of Task Force Members
- Agenda Revisions
- Submission of Documents
- Approval Previous Meeting Minutes
  (1:00 P.M. - 1:15 P.M.)

- Opening Remarks Co-Chairs
  (1:15 P.M. - 1:20 P.M.)

- Rep. Jonathan Singer
  (1:20 P.M. - 1:30 P.M.)

- Report on Workers Compensation Process
  Dr. Kathryn Mueller - Medical Director - Division of Workers Compensation
  (1:30 P.M. - 2:00 P.M.)

- Presentation by the Fraternal Order of Police/Personal Story
  (2:00 P.M. - 2:30 P.M.)

- Break
  (2:30 P.M. - 2:45 P.M.)

- Formation of Committees
  Advisory Legislative Committee - legislative issues and gaps
  Advisory Policy Committee - Identify current gaps in the process, make recommendations

Appendix B

Planning and Technical Committee - provide technical assistance, other areas of study as identified by task force members, outreach if needed, and responsible for the draft of final report for our review. Ensure goals of legislature are met.

- Unfinished Business
- New Business
  (2:45 P.M. - 3:00 P.M.)

- Public Comment
  (3:00 P.M. - 3:30 P.M.)

- Set Date of Next Meeting (Late September/early October)
- Adjournment

Appendix B

Peace Officer PTSD Task Force
Notes
August 14, 2014

In attendance: Tom Wickman, Dr. Kathryn Mueller, Danny Veith, Rick Thompkins, Markie Davis, Jack Wylie, Jim Crone, George Hartlaub, Ralph Trenary, Joseph Hoy, Suzette Freidenberger, John Nicoletti, Leny Robinson, Sean Harper, and Karl Wilmes.

The meeting was called to order at 1300 hours.

The pledge of allegiance was recited

The notes from previous meeting were approved.

Open remarks were made by Sean Harper. He gave a brief overview of the attempt to get the original bill passed in 2013. The word presumptive became the sticking point and the bill was not accepted. The bill was rewritten and the Peace Officer PTSD Task Force was formed.

The floor was turned over to Dr. Kathryn Mueller, the Medical Director-Division of Workers Compensation. Dr. Mueller stated she began her career in emergency medicine and has been an EMS medical director.

Dr. Mueller gave an overview of what a workers compensation provider needs to consider when addressing a patient.

First they will make a diagnosis then determine a course of treatment. The treatment plan will be shared with the employer. The employer has the option to accommodate any work restrictions, etc., but are not required to find alternative duty for the injured employee. During this treatment phase the employee is eligible for temporary disability pay for the hours they cannot work.

Treatment is provided via workers compensation until maximum medical improvement is reached. This means a point in time when any medically determinable physical or mental impairment as a result of injury has become stable and when no further treatment is reasonably expected to improve the condition. At this time temporary disability pay is discontinued. If the employee cannot return to full duty, they will receive permanent total disability if they can no longer work at any job. They will receive permanent partial disability if they can work, but cannot perform the duties of their current job.

Dr. Mueller was asked if, in the workers compensation system, the professional making the diagnosis is always a physician. Yes it is.

Dr. Nicoletti clarified that even in the event that the patient's injury is psychological in nature the workers compensation provider making the diagnosis will be a physician not a psychologist. Dr. Mueller confirmed that is correct.

Dr. Mueller referenced the following section of the CRS as it may be applied to PTSD.

A claim of mental impairment must be proven by evidence supported by the testimony of a licensed physician or psychologist. For purposes of this subsection (2), "mental impairment" means a recognized, permanent disability arising from an accidental injury arising out of and in the course of employment when the accidental injury involves no physical injury and consists of a psychologically traumatic event that is **generally outside of**

a worker's usual experience and would evoke significant symptoms of distress in a worker in similar circumstances. A mental impairment shall not be considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, lay-off, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer. The mental impairment that is the basis of the claim shall have arisen primarily from the claimant's then occupation and place of employment in order to be compensable.

Suzette Freidenberger asked how qualified the workers comp doctors are to determine a diagnosis of PTSD and what is their responsibility to refer. The workers comp provider is not required to make a referral for diagnosis.

A discussion followed as to how a workers compensation doctor would determine if the event was outside a worker's usual experience. Do they refer to job descriptions, are they trained in the realities of the work, or is it based on general perception? Dr. Mueller stated that physicians will obtain job descriptions from employers to use in making these determinations.

It should be noted that if the traumatic event is accompanied by a physical injury it does not matter if the event is generally outside the worker's usual experience.

There was discussion as to how to alleviate the problems caused by this phrase. Would documenting exposure over time be beneficial? Changing the language and how should it read. Do you attempt to establish a definition what events would or would not be considered a usual experience? It was noted that many of the normal duties of a law enforcement officer or other emergency responders can and do lead to PTSD.

The Executive Director of the Department of Workers Compensation, Paul Trujillo, stated that the current statute does allow each side remedies. The employer has options for denying claims and the employee for appealing those denials.

A law enforcement officer then gave testimony on his personal experience with developing PTSD.
He described how it has affected all aspects of his life, including a period of considering suicide. He spoke about some specific incidents throughout his career that continue to cause him a great deal of emotional distress. The PTSD has resulted in his no longer being able to function in his role as a police officer. At the time he had to leave his job, he sought compensation through workers compensation. The workers comp doctor denied his claim even though he had documentation from the psychologists who had been treating him, stating he had been diagnosed with PTSD and that it was caused by things he had experienced during the course of his work. This diagnosis was also supported by the psychologist the workers comp doctor referred him to.

Representative Jonathan Singer took a few moments to thank the task force for their time. He felt there had been a high degree of honesty and candor. He would like to be present for the committee and provide support as he can. Representative Singer asked what the task force would like his role to be.

The task force asked that he help keep them on track and provide feedback on the political climate as it pertains to this topic. They would also like him to let them know if things not suited to legislation are being included.

He was asked what happens if the task force does not reach a consensus. The rules of the task force will determine what is needed to pass on the recommendation. These rules can be set as the task force sees fit. There are various options, degrees of majority for example.

The task force asked the following questions of the police officer who gave testimony. Would early intervention have help? Yes possibly. What is his goal in filing the workers comp claim? To be assured that

he can continue to receive treatment and be covered financially. The officer would like it to be recognized that doing the work he did, does have an effect on mental wellbeing and the employer owes him help.

Would mandatory help have been of benefit? He did not think that mandating the process would have been helpful. It would have been helpful to have experts within the department to recognize the symptoms of stress and reach out to help.

The officer's attorney in his suit to obtain workers compensation was asked what does he feel needs to be done to minimize denials in these cases.

He feels that the verbiage needs to be cleaned up, made less interpretive. If you are injured during the course of your job, whether it is mental or physical, it is covered.

The comment was made that based on this officer's experience, one doctor within the workers comp system can derail / deny what seems to be a legitimate claim for compensation.

Three subcommittees were formed.

Advisory Policy Committee:
Will identify gaps in the policy of treatment. Look at prevention, treatment, etc. and the process of getting it. Consists of Dr. Mueller, Danny Veith, Rick Thompkins, Jim Crone, Dr. Hartlaub, Dr. Nicoletti, and Suzette Freidenberger.

Planning Technical Committee:
Will research best practices and provide research data to support them or disprove their effectiveness. They can enlist the help of the Legislative Council. Consists of Ralph Trenary, Tom Wickman, Representative Singer's intern.

Advisory Legislative Committee:
Will be responsible for crafting the language for the proposed changes. Consists of Paul Fisher, Joseph Hoy, Jack Wylie, Markie Davis, and Brenda Leffler.

Sean Harper advised the Advisory Legislative Committee that the previous bill included a death benefit. There will be more information presented about this so they may want to put that piece aside until then.

Unfinished Business

Who will call the subcommittees? Each will be self-governed and set their own meetings.

New Business

None

Public Comments

Mike Violette with the Colorado FOP noted that the FOP sees these workers comp claims being denied on a regular basis. He emphasized that when these officers develop PTSD it is a life changing event, emotionally and financially

The Peace Officer PTSD Task Force will meet again on Tuesday, October 7, 2014 at 1:00 p.m.

Appendix B

LEGISLATIVE TASK FORCE

Peace Officer PTSD Task Force Public Meeting Agenda

Tuesday, October 07, 2014 – 1:00 p.m.
Colorado State Capitol
House Committee Room 0112, Basement
200 E Colfax Ave, Denver, CO 80203

- Call Meeting to Order at 1:00 PM
- Pledge of Allegiance
- Roll Call of Task Force Members
- Opening Remarks of Rep. Jonathan Singer/Co-Chairs
- Approval Previous Meeting Minutes
- Agenda Revisions
- Submission of Documents
- Action Items Pending Review
- Sub-Committee Reports
  - -Advisory Legislative Committee (Discussion)
  - -Advisory Policy Committee (Discussion)
  - -Planning and Technical (Discussion)

- Action Items
- New Business
- Invited Speakers (Chief John Jackson)
- Public Comment
- Set Date of Next Meeting & Adjournment

Appendix B

MINUTES OF COLORADO LEGISLATIVE TASK FORCE - PEACE OFFICER PTSD

Meeting Date October 7, 2014

Call to order: A regular meeting of the Peace Officer PTSD Task Force was held in the State Capital Building, Denver Colorado on October 7, 2014. The meeting convened at 1306. Task Force Co-Chair Sean Harper presiding.

Members in attendance were Ken Poncelow, Terry Campbell, Tom Wickman, Brenda Leffler, George Hartlaub, Ralph Trenary, Joseph Hoy, Jack Wylie, Danny Veith, Jim Crone, Eric Bergman, John Nicoletti, Markie Davis, Paul Fisher, Karl Wilmes, Kathryn Mueller, and Lenya Robinson. Members not in attendance were Suzette Freidenberger and Rick Thompkins.

The pledge of allegiance was recited.

Chief John Jackson of the Greenwood Police Department gave testimony as the President of the Colorado Association Chiefs of Police.

Chief Jackson began by saying he would like to take the liberty to explain to some degree how we got here today. Because the Colorado Association of Chiefs of Police, I think, has been engaged and instrumental in the process since the start. They have worked diligently with Representative Singer on many different issues and I think it is important to hear from me how and why we chose the position that we did.

The CACP agrees that post-traumatic stress is a concern and acknowledge it as a medical condition. They initially opposed the previous draft of the PTSD / Worker's Comp bill because of the way it was written. Chief Jackson named 6 key areas of the bill that CACP wanted worked out before they could actively support it. They are:

1) The presumption that a police officer has PTSD if they participated or saw one of four simple things.

2) There was a concern that the qualifying factors of PTSD are common documented occurrences in the line of duty. We all get into the this job knowing full well what we're going to witness, see, and ultimately may be a part of. That doesn't mean that it diminishes the value or that or that we should not address it as it happens, but there is an acknowledgement that on duty, normal things can cause PTSD.

3) There is a concern about the department being responsible for the expenses even if the employee is found not to have PTSD.

4) A concern about broad definition with regard to injury and disease. We need to narrow the scope of those to where it is applicable to on-duty injury.

5) The looseness in the definition and presumption of PTSD. A more specific definition could cleanly fix the majority of these concerns.

6) Officer cannot use PTSD as an out or way to derail discipline.

Chief Jackson noted that 95 percent of the respondents to a survey he sent out would qualify for PTSD under the guidelines in the previous bill.

Chief Jackson went on to speak about ways that his and other agencies are currently providing help to officers and other LE personnel who have experienced traumatic incidents on duty. Some agencies have staff psychologists, some have contracted psychologists. He noted that covering emotional survival techniques during field training and on-going during an officers career could be instrumental helping to address post-traumatic stress. Chief Jackson also stated that civilian staff should not be discounted in this effort.

Chief Jackson then answered questions from the task force members.

At 1350 the task force took a 10 minute break.

Meeting reconvened at 1402.

Representative Singer thanked the task force for their good work and reminded them he is available to help.

Sean Harper reminded the task force members that the original bill is no longer on the table. The goal of task force is to research work related peace officer post-traumatic stress disorder and other relative topics as determined by the task force and make recommendations that include best policies and practices. The task force will not be creating legislation.

Karl Wilmes stated the rest of the meeting would be spent on subcommittee reports.

Brenda Leffler – Chair of the Advisory Legislative Committee reported they met once in the interim. The committee members would like to put prevention on the table along with response and recovery. They would also like to see the culture addressed. A request was made of the legislative council to research the number of claims that have been made relating to PTSD and the best practices of other law enforcement agencies and the military in regards to treating / preventing PTSD. They feel the need for more direction from the other sub-committees before moving ahead.

John Nicoletti – Chair of the Advisory Policy Committee reported this committee did not meet. John had put together the following list of talking points and comments. Event horizon, mandatory referral to mental health professional would take away stigma. Pre-event education with the focus on how do we increase resilience. Post event, recognizing that experiencing PTSD is the only injury in the workers comp system that is treated as a job requirement. The last talking point was developing resources.

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Ralph Trenary – Chair of the Planning and Technical Committee reported this committee did not meet. They are waiting for more information to be gathered and would like to meet with Representative Singer regarding the outline and framework of the report. They have assigned research to members.

The Advisory Legislative committee is responsible for making recommendations as to what will possibly go into a bill.

The Advisory Policy committee will focus on prevention, intervention, awareness training and things like that.

The Planning and Technical committee is responsible for constructing the final report.

The subcommittee chairs were established. Brenda Leffler – Advisory Legislative Committee, John Nicolletti – Advisory Policy Committee, and Ralph Trenary – Planning and Technical Committee.

The committees were directed to submit all items to be researched by the legislative council to Representative Singer soon.

The following requests for research will be made to the legislative council.

The number of claims made to workers comp for PTSD by law enforcement.

The best practices from law enforcement.

The best practices from the military.

Any issues with discipline

How many claims have been made in Oregon, how many challenges / denials. What financial impact has there been? Who approves or denies the diagnosis / claim?

Information on Ohio state bill 252; which addresses PTSD in law enforcement.

Sean Harper will forward the Oregon CRS regarding workers comp and mental injury.

Ken Poncelow will request information through the Oregon Chiefs of Police organization.

John Nicoletti will request information on how many PTSD cases they have on average.

Ralph Trenary will contact Charlene Shields with Family and Member Services – National Guard and Reserves.

Appendix B

Kark Wilmes asked that each committee meet at least one time before the next task force meeting. He asked that each committee come up with a list of recommendations. These do not have to be legislative in nature.

The Advisory Legislative committee was tasked with taking a look at the definitions. Suggestions were on duty / off duty and PTSD.

The Advisory Policy committee was tasked with identifying current gaps in the process. Some examples were what is taught by POST? Involving spouses in education. Including civilian staff in who is covered.

The Planning and Technical committee was tasked with consolidating information from the various sources and other sub-committees and distributing it to the entire task force.

The goal for the next meeting to create a list of recommendations.

Sean Harper asked if the next meeting, November 12th, could begin at noon instead of 1:00 pm to allow time for testimony from expert witnesses. There are at least 3 people who have expressed interest in attending.

Sean Harper would like to see the bulk of the work completed by the December meeting. With the final draft completed for review early January.

The task force members should forward their individual thoughts and experiences to Ralph Trenary.

Ralph Trenary will create an outline and get that out to the members.

There was no new business.

There were no public comments.

Ken Poncelow went over preliminary results from the survey about PTSD that was put on Survey Monkey. This survey closes on October 31st.

Meeting adjourned at 1500.

Appendix B

LEGISLATIVE TASK FORCE

Peace Officer PTSD Task Force Public Meeting Agenda

Wednesday, November 12, 2014 – 12:00 p.m.
Colorado State Capitol
House Committee Room 0112, Basement
200 E Colfax Ave, Denver, CO 80203

- Call Meeting to Order at 12:00 P.M.
- Pledge of Allegiance
- Roll Call of Task Force Members
- Opening Remarks of Rep. Jonathan Singer/Co-Chairs (12:00 P.M.-12:15 P.M.)
- Approval Previous Meeting Minutes
- Agenda Revisions (12:15 P.M.-12:30 P.M.)

Sub-Committee Reports

- Legislative Committee –Chair LTC Brenda Leffler
  Report (12:30 P.M.-12:45 P.M.)
  Discussion (12:45 P.M.-1:30 P.M.)
- Advisory Policy Committee Chair Dr. John Nicolletti/Danny Veith
  Report (1:30 P.M.-1:45 P.M.)
  Discussion (1:45 P.M.-2:15 P.M.)

BREAK (2:15 P.M.-2:30 P.M.)

- Planning and Technical Committee Chair Ralph Trenary
  Report (2:30 P.M.-2:45 P.M.)
  Discussion (2:45 P.M.-3:15 P.M.)

Invited Speakers

- Marilyn Meyers – Public Safety Psychologist (3:15 P.M.- 3:35 P.M.)
  Discussion (3:35 P.M.- 3:45 P.M.)
- Ken Platt – Former Director of CO Workers Comp (3:45 P.M.- 4:05 P.M.)
  Discussion (4:05 P.M.- 4:15 P.M.)
- Ron Clark – Chairman of the Board-Badge of Life (4:15 P.M.- 4:35 P.M.)
  Discussion (4:35 P.M.- 4:45 P.M.)

- Action Items
- Submission of Documents
- New Business
- Public Comment
- Set Date of Next Meeting & Adjournment (4:45 P.M.- 5:00 P.M.)

Appendix B

MINUTES OF COLORADO LEGISLATIVE TASK FORCE - PEACE OFFICER PTSD

Meeting Date November 12, 2014

Call to order: A regular meeting of the Peace Officer PTSD Task Force was held in the State Capital Building, Denver Colorado on October 7, 2014. The meeting convened at 1213. Task Force Co-Chair Sean Harper presiding.

Members in attendance were Karl Wilmes Ken Poncelow, Terry Campbell, George Hartlaub, Ralph Trenary, Joseph Hoy, Jack Wylie, Danny Veith, Jim Crone, John Nicoletti, Markie Davis, Paul Fisher, Kathryn Mueller, and Suzette Freidenberger. Members not in attendance were Tom Wickman, Lenya Robinson, Brenda Leffler, Rick Thompkins, and Eric Bergman.

The pledge of allegiance was recited.

Minutes from last meeting were approved.

Markie Davis reported for the Advisory Legislative Committee.

They would like to see the following items considered.

Update the definition of PTSD in the workers comp statute.

Ensure that any solution will include all employees not just law enforcement and corrections officers.

The wording **generally outside of a worker's usual experience and would evoke significant symptoms of distress in a worker in similar circumstances,** needs to be changed to allow law enforcement and other emergency works more consistent access to treatment and compensation.

Include peace officers' actions off duty, as they relate to law enforcement, as falling under workers compensation.

Consider media campaigns specifically targeting law enforcement. Possibly using South Carolina as a model.

Explore preventative / resiliency training through POST. Explore best practices for preventative treatment.

Make treatment easily available across the state.

Fix the problem of reduced pay during treatment and on disability pay.

The changes should include all workers who are regularly exposed to trauma.

There is a concern that if the bill is too encompassing it will garner more opposition.

All suggestions can be included in the final report, it will be made clear that our recommendations are focused on law enforcement.

No time limit between exposure and appearance of symptoms was discussed because of accumulated exposure. This would be similar to other cumulative injuries such as carpal tunnel. The resulting injury is known to come from extended exposure.

Mike Violette advised that Representative Singer would like to see a number of options presented in the final report. This will allow him to craft a bill that will be most successful.

John Nicoletti reported for the Advisory Policy Committee.

They utilized a GAP Analysis format which focused on trauma awareness, mitigation and recovery.

Pre-event horizon is the phase before and officer has experienced trauma exposure. There is a need for trauma related training both during the academy and in house. Agencies need to have policies or protocols for assignments or events that can potentially produce a traumatic response (child porn assignments, mass casualty events, etc).

It would be beneficial for agencies to have subject matter experts to assist in the inoculation process. Making resources available to all agencies (peer support, CISM response) is needed.

Event horizon is the phase when the officer has either experience acute or long term trauma exposure. There is a need for guidelines regarding traumatic incidents other than officer involved shootings. Skilled resources need to be readily available to all law enforcement agencies. Need to address stigma around seeing EAP or peer support following an incident. Addressing the impact of social media in response to a traumatic event.

Post event horizon is the phase in which an officer has developed PTSD or is experiencing significant traumatic reactions due to intrusions and flashbacks. PTSD needs to be recognized as an injury resulting from an incident or accumulation of incidents. It should not be viewed as part of the job. Once an officer enters into workers comp, there is a concern about the confidentiality.

They recommend that mental health practitioners involved in psychological interventions follow up with officers at one and four month intervals and the anniversary of the incident.

Peer Support should be developed and utilized in agencies.

Options for developing and providing some of the recommended training and services were discussed.

Ralph Trenary reported for the Planning and Technical Committee.

They continue to gather information submitted by the other committees. He feels they will be able to create a solid draft for everyone to work from by the beginning of December. He feels the report should include a full record of documents and information from everyone who gave presentations.

Ralph asked that the committees and individuals get all documents and references they would to see included to the planning and technical committee.

What to do if a recommendation does not get full consent was discussed.

The meeting took a 15 minute break at 1350.

After the break Dr. Meyers spoke to the task force.

Dr. Meyers advised she has treated a number of employees for PTSD. The first concern of the employer is how much will the treatment cost. **Studies indicate that the cost of treatment and retention is half of what employers will spend if the employee is replaced.** Dr. Meyers noted that for physical injury coverage, insurance premiums are often reduced if the employer provides safety training. Psychological safety training would be beneficial for the employees and may result in decreased coverage costs.

Dr. Meyers spoke about some of her experiences with workers comp and law enforcement and how these two systems can work in complement of each other and how they are different from other systems.

In one instance she was hired as an independent consultant in a mental / mental claim. The claimant was suffering from anxiety and panic disorders. It was determined that the employee's encounters fell within the scope of what would normal for their position and that there were additional factors in her personal life that contributed to her disorders. The claim was denied.

In another case, the employee involved was the victim of an armed robbery. No psychological intervention was given. The employee was transferred to another location in an attempt to alleviate her anxiety. Also security personnel were hired. The subject witnessed an armed man approaching the new location. She panicked, hid and heard gun shots. After that time a claim for disability was filed with workers comp. It was determined that she would not be able to function at any job and the claim was supported.

The final example referenced an officer involved in a shooting. The officer initially felt they were doing okay and returned to work. One year after the incident, the officer entered into treatment for post-traumatic stress. In this instance the workers comp claim was denied, but the officer's employer agreed to pay for their treatment.

Dr. Meyers then spoke about the fact that there a very limited number of IME physicians.

In Dr. Meyers experience, when claim adjusters seek a second opinion they can and do choose someone who is most likely to support their desired outcome. This is proven in part by the fact that there are quite a few doctors available to provide a second opinion, but only a handful are used on a regular basis.

A final sticking point when it comes to mental / mental claims is the need to determine when the maximum level of improvement has been reached, and how long will that take.

Attorney Ken Platt was the next speaker.

He has represented many people in workers comp claims. He stated that the workers comp system is not easy to work within.

He feels that the lack of providers is a big problem when it comes to mental health services. Not many psychologists are willing to provide services under workers comp.

In his experience, most law enforcement personnel want to get back to work.

Ken noted that because PTSD leads to other behavior problems, it is difficult sometimes to connect it back to a specific work related event.

In the end, the truth is that insurance companies are responsible for the money, not the people seeking services.

Based on the maximum amount of money an officer can receive from workers comp while in treatment, he feels the concerns about abuse are unfounded. Jack Wylie clarified that the salary amount is limited, but there is no maximum on payment of medical costs for a worker's comp claim.

Ron Clark – Chairman of the Board Badge of Life.

The Badge of Life organization was established in 2006. Their focus is suicide prevention and mental health for police officers. The goal is to teach officer how to stay out of emotional trouble in the first place.

It is estimated that 8 to 18% of officers are currently diagnosable with PTSD. Getting them the right treatment is of paramount importance.

Ron spoke about his support of the task force and their work towards developing a workers comp statute regarding PTSD that can be used as a guide post for other states.

It is clear we need a better approach.

Action items for next meeting:

Ralph Trenary and Addie will put all the information together in a draft. This will be sent out to the taskforce members by the 1st of December.

The next meeting will be to make any changes and finalize the draft.

There was no new business.

There were no public comments.

The next meeting will be held on December 10, 2014 at 1300 hours.

Appendix B

LEGISLATIVE TASK FORCE

Peace Officer PTSD Task Force Public Meeting Agenda

Wednesday, December 10, 2014 – 1:00 p.m.
Colorado State Capitol
House Committee Room 0112, Basement
200 Colfax Ave, Denver, CO 80203

- Call Meeting to Order at 1:00 PM
- Pledge of Allegiance
- Roll Call of Task Force Members
- Opening Remarks of Rep. Jonathan Singer/Co-Chairs
- Approval Previous Meeting Minutes
- Agenda Revisions
- Submission of Documents
- Action Items Pending Review
- Final report Discussion
- Action Items
- New Business
- Public Comment

- Set Date of Next Meeting & Adjournment

Appendix B

MINUTES OF COLORADO LEGISLATIVE TASK FORCE - PEACE OFFICER PTSD

Meeting Date December 10, 2014

Call to order: A regular meeting of the Peace Officer PTSD Task Force was held in the State Capital Building, Denver Colorado on December 10, 2014. The meeting convened at 1303. Task Force Co-Chair Sean Harper presiding.

Members in attendance were Karl Wilmes Ken Poncelow, Terry Campbell, Ralph Trenary, Joseph Hoy, Jack Wylie, John Nicoletti, Markie Davis, Paul Fisher, Brenda Leffler, Suzette Freidenberger, Tom Wickman, Rick Thompkins, George Hartlaub, and Lenya Robinson. Members not in attendance were Kathryn Mueller, Danny Veith, Jim Crone, and Eric Bergman.

The pledge of allegiance was recited.

Representative Singer thanked Representative Wright for and the task force members for their work on this topic.

The floor was opened for remarks. There were none.

Minutes from last meeting were approved.

Ralph Trenary advised that due to circumstances he was not able to compile the information received from the other sub-committees. Dr. Meyers and Addie will be helping with this process.

Addie advised that the documentation received has been converted to PDF files and are available for viewing on Google Doc web site. She will send the link and instructions to the task force members.

Brenda Leffler gave an overview of the Advisory Legislative Committee's recommendations.

Include a definition of PTSD. They suggested using the current definition from the DSM. Or a definition approved by worker's comp.

Make clear that law enforcement personnel are covered while on scheduled duty or when acting in their LE roll while off duty.

They did not establish a recommendation for reporting exposure to mental trauma.

Strong recommendation for education and support.

There was discussion about how to provide psychological services across the state. Options mentioned were, the Department of Health and Human Services floating councilors, Mayflower team, Recovery International, and peer support.

Define how we report and file claims.

Determine what is needed to establish a cumulative injury.

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Establishing a psychological base line at the time of hiring would help prove the cause was job related.

Expand coverage to include non-commissioned law enforcement personnel, i.e. dispatchers, victim advocates.

Address the statement "**generally outside of a worker's usual experience and would evoke significant symptoms of distress in a worker in similar circumstances** in the current statute.

Representative Singer would like to have a signification number of recommendations/suggestions to utilize in writing the bill.

Representative Singer asked for the task force's opinion of the previous bill. He specified the portion of the previous bill that allowed payment of death benefits if a suicide is determined to be the result of psychological trauma experienced on the job. He feels that feedback from the task force on the previous bill would be helpful in drafting the next bill.

Ralph Trenary asked that Representative Singer submit a list of questions for the task force to respond to.

Sean Harper asked if the task force members were ready to vote on the recommendation to change the wording "**generally outside of a worker's usual experience and would evoke significant symptoms of distress in a worker in similar circumstances."** None were. They feel any voting needs to be held after the draft report is completed and reviewed.

At 1433 the task force took a break.

The meeting reconvened at 1447.

All members of the task force need to get all documentation to Ralph Trenary and Addie. Ralph requested that everyone review their notes and begin putting ideas and action items into the appropriate section of the outline.

It was requested that all findings and recommendations be submitted to Addie by December 18th.

There was no new business.

There were no public comments.

The next meeting will be on January 5th at 1300. It was noted there will be a need to have access to a computer and the displays at that meeting.

The meeting adjourned at 1509.

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LEGISLATIVE TASK FORCE

Peace Officer PTSD Task Force Public Meeting Agenda

Monday January 05, 2015 - 1:00 P.M.
Colorado State Capitol
House Committee Room 0112, Basement
200 E Colfax Ave, Denver, CO 80203

- Call Meeting to Order at 1:00 P.M.
- Pledge of Allegiance
- Roll Call of Task Force Members
- Opening Remarks of Rep. Jonathan Singer/Co-Chairs (1:00 P.M.-1:15 P.M.)
- Approval Previous Meeting Minutes
- Agenda Revisions (1:15 P.M.-1:30 P.M.)

- **Planning and Technical Committee - Chair Ralph Trenary Report** (1:30 P.M.- 2:00 P.M.)

- Committee Discussion on Final Recommendations (2:00 P.M. – 2:30 P.M.)

BREAK **(2:30 P.M.-2:45 P.M.)**

- Vote of Task Force Members on Recommendations (2:45 P.M.-3:15 P.M.)
- Action Items
- New Business
- Public Comment
- Meeting Adjournment (3:15 P.M.- 3:30 P.M.)

Appendix B

MINUTES OF COLORADO LEGISLATIVE TASK FORCE - PEACE OFFICER PTSD

Meeting Date January 5, 2015

Call to order: A regular meeting of the Peace Officer PTSD Task Force was held in the State Capital Building, Denver Colorado on January 5th, 2015. The meeting convened at 1303. Task Force Co-Chairs Sean Harper and Brenda Leffler presiding.

Members in attendance were Eric Bergman, Terry Campbell, Jim Crone, Markie Davis, Paul Fisher, Suzette Freidenberg, Sean Harper, George Hartlaub, Joseph Hoy, Brenda Leffler, Kathryn Mueller, Ken Poncelow, Lenya Robinson, Rick Thompkins, Ralph Trenary, Danny Veith, Tom Wickman, Jack Wylie and Dr. Merilyn Meyers (standing in for Dr. John Nicolette).

The purpose of this meeting was to finalize the recommendations from this task force.

Each recommendation was reviewed and discussed. The desired changes were noted by Addie and Ralph.

The primary focus was to ensure that most of the items be recommendations only. It is understood by the task force that mandating training, policies, and other actions becomes a financial and time burden to individual agencies.

The final item on the recommendations list is specific to the workers' compensation statute. Throughout the course of this task force, testimony and discussion would indicate that the wording of the statute has contributed to mental only claims by law enforcement personnel being denied. Primarily that the situation that gave rise to the claim was considered a usual occurrence in the officer's job. The recommendation that legislation look at modifying the wording was agreed upon by the task force members who did not abstain.

The issue of documentation / exposure reports was discussed at length. It was decided not to include this as a recommendation.

Ralph Trenary and Addie Hodge will have the revised draft out to the task force members by Friday January 9th. The goal is to have the final documents done and delivered to legislative services on January 15th.

The task force is in effect until December 31st of 2015.

In closing thanks were expressed to all the task force members for their work and dedication.

Pre-Employment Psychological Evaluation Guidelines

Ratified by the IACP Police Psychological Services Section
Denver, Colorado, 2009

1. Purpose

1.1. The IACP Police Psychological Services Section (PPSS) developed these guidelines for use by public safety agencies and individuals who are charged with the responsibility of conducting defensible pre-employment psychological evaluation programs.

2. Limitations

2.1. These guidelines are not intended to establish a rigid standard of practice for pre-employment psychological evaluations. Instead, they are intended to reflect the commonly accepted practices of the PPSS members and the agencies they serve.

2.2. Each of the guidelines may not apply in a specific case or in all situations. The decision as to what is or is not done in a particular instance is ultimately the responsibility of each hiring agency and psychologist.

2.3. Nothing in these guidelines should be construed to discourage scientific research, innovation, and/or use of new techniques that show promise for helping hiring agencies identify, screen, and select qualified candidates. Hiring agencies and psychologists who choose to use these practices may wish to consult with legal counsel to assess the potential liability exposure.

2.4. These guidelines are written to apply to agencies within the jurisdiction of the United States and, as such, may require modification for use by agencies in other countries.

3. Definitions

3.1. For the purpose of these guidelines, a pre-employment psychological evaluation is a specialized examination of an applicant's psychological suitability for a public safety position. These positions include, but are not limited to, positions where incumbents have arrest authority or the legal authority to detain and confine individuals.

3.2. Psychological suitability includes, at a minimum, the absence of job-relevant mental or emotional conditions that would reasonably be expected to interfere with safe and effective performance.

3.3. Under the terms of the Americans with Disabilities Act[1] (ADA) a procedure or test that seeks information about an individual's physical or mental impairments or health, or that provides evidence that would lead to identifying a mental disorder or impairment, is a "medical examination." Therefore, a pre-employment psychological evaluation constitutes a medical examination.

3.4. A pre-employment psychological evaluation may include procedures or tests that are not medical in nature (i.e., designed and used to measure personality traits, behaviors, or characteristics such as judgment, stress resilience, anger management, integrity, conscientiousness, teamwork social competence). However, these non-medical procedures alone would not constitute a complete pre-employment psychological evaluation since they do not include the required elements specified in 3.2 and 3.3.

3.5. The ADA plays an important role in the timing of when the evaluation can be performed in the hiring process. Under the ADA, the use of medical inquiries or examinations may occur only after (a) the hiring agency has obtained and analyzed all relevant non-medical information which it reasonably could have obtained and analyzed, and (b) the applicant has been given a conditional offer of employment.

4. Examiner Qualifications

4.1. Evaluations should be conducted by licensed doctoral-level psychologists, except where otherwise permitted by law, with expertise in clinical psychological testing and assessment, as well as in personnel evaluation using measures of normal personality characteristics, skills, and abilities. Psychologists should also be trained and experienced in psychological evaluations for public safety positions, in particular.

4.2. Psychologists should be familiar with the research literature available on psychological testing for public safety positions. Psychologists should also be familiar with employment law impacting the conduct of pre-employment psychological evaluations, including but not limited to the ADA, or other federal and state laws applicable to the practitioner's jurisdiction. Psychologists should consult with legal counsel when appropriate.

4.3. Psychologists must adhere to ethical principles and standards for practice in their jurisdiction.

[1] Please see the Equal Employment Opportunity Commission's Enforcement Guidance, *ADA Enforcement Guidance: Preemployment Disability-Related Questions and Medical Examinations*, at www.eeoc.gov/policy/docs/preemp.html.

5. Job Analysis

5.1. Information about duties, powers, demands, working conditions, and other job-analytic information relevant to the intended position, should be obtained by the psychologist before beginning the evaluation process. This information should be directed toward identifying behaviors and attributes that underlie effective and counterproductive job performance.

5.2. The psychologist should consult with the hiring agency to establish selection criteria and the agency's level of acceptable risk for problematic behaviors.

6. Disclosure

6.1. Prior to the administration of any psychological instruments and interview, the psychologist and/or hiring agency should disclose information to the applicant that includes (1) the nature and objectives of the evaluation, (2) the intended recipients, (3) that the hiring agency is the client, (4) the probable uses of the evaluation and the information obtained, (5) who will have access to the information, and (6) the limits of confidentiality.

6.2. The disclosure should be documented in writing and signed by the applicant.

7. Testing

7.1. **Use:** A written test battery, including objective, job-related psychological assessment instruments, should be administered to the applicant. Test results should be available to the evaluator before the interview is conducted.

7.1.1. The licensed psychologist should always retain responsibility to verify and interpret all psychological test results.

7.1.2. Tests should be administered, scored, and interpreted according to the publisher's recommendations and consistent with established test administration standards.

7.1.3. Test scales, profiles, and reports used for selection purposes should be produced using appropriate, current software or scoring keys licensed by the publisher of the test.

7.2. **Validity:** Written assessment instruments should have validation evidence for use with public safety applicants.

7.2.1. Tests should have a substantial research base for interpretation with normal range populations in general and public safety applicants in particular. Validation evidence should be consistent with *Principles for the Validation and Use of Personnel Selection Procedures*.[2]

[2] Please see the *Principles for the Validation and Use of Personnel Selection Procedures*, 4th ed., August 2003, at http://www.siop.org/_Principles/principles.pdf.

7.2.2. Specific cut-off scores should be used only when there is adequate statistical evidence that such scores are predictive of personality or mental health problems that are detrimental to job performance. If cut-off scores are used, the psychologist should acknowledge their use and be prepared to provide the justification for using the specific cut-off level.

7.2.3. New or emerging psychological instruments may be added to a battery to develop the requisite norms and validation, but should not be used for decision making by the evaluating psychologist during the data gathering process.

7.3. **Security:** The psychologist should make provisions for the security and confidentiality of all testing materials (e.g., test booklets/items) including materials presented electronically. Provisions should also be made for the security of, access to, and retention of the psychological reports and raw data, including information stored or transmitted electronically.

8. Interview

8.1. Individual, face-to-face interviews with applicants should be conducted before a final determination of the applicant's psychological suitability is made.

8.2. A semi-structured, job-related interview format should be employed with all applicants.

8.3. Interviews should allow for sufficient time to cover appropriate background, test results verification, and clinical assessment.

9. Background Information

9.1. Information regarding the applicant's relevant history (e.g., school, work, interpersonal, family, legal, financial, substance use, mental health) should be collected and integrated with psychological test and interview data. When available, relevant information from the background investigation and polygraph examination should be shared with the psychologist.

9.2. If relevant to psychological suitability, health records should be obtained from treating healthcare professional(s) for review before a final determination is made of the applicant's suitability. When such records are unavailable, consideration should be given to deferring the suitability determination until the health record can be reviewed or the basis for the concern is otherwise resolved.

9.3. When background investigation findings are not provided to the psychologist in advance of the evaluation, it is desirable for the psychologist to communicate with designated hiring agency staff, prior to making a final suitability determination, to compare and reconcile information obtained from the applicant. In all cases, substantive discrepancies between information obtained

in the psychological evaluation and other stages of the hiring process should be reviewed thoroughly with the hiring agency before a final hiring decision is made.

10. Reports

10.1. The hiring agency administrators directly involved in making employment decisions should be provided with a written report of the psychologist's evaluation. The report should contain, at a minimum, a clear determination of the applicant's psychological suitability for employment based upon an analysis of all psychological assessment material, including background information, test data, and interview results. Any agency-specific restrictions or other requirements relevant to the format or content of the psychological report should be communicated to the psychologist in advance of the evaluation.

10.2. Ratings and/or recommendations for employment based upon the results of the evaluation should be expressly linked to the job-analytic information referenced in paragraphs 5.1 and 5.2.

10.3. While a clinical assessment of overall psychological suitability should be made, clinical diagnoses or psychiatric labeling of applicants should be avoided unless relevant to the psychologist's conclusion, necessary for the hiring agency to make an employment decision, and/or required by law. In all cases, the evaluation should be focused on an individual applicant's ability to safely and effectively perform the essential functions of the position under consideration.

10.4. Conclusions concerning an applicant's qualifications should be based generally on consistencies across data sources rather than a single source; psychologists should justify exceptions to this guideline.

10.5. Additional information, including ratings, recommendations, justifications for the recommendation and/or rating, reservations that the psychologist might have regarding the validity or reliability of the results, and other elements required by law in the hiring agency's jurisdiction, should be disclosed on a need-to-know basis, in consultation with the hiring authority.

10.6. The report should clearly state the period of time for which the evaluation is considered valid. In the absence of a legally prescribed limitation, reports should be valid for no longer than one year from completion of the evaluation.

10.7. The written report provided to the agency should be securely maintained in accordance with applicable regulations.

11. Use of the Evaluation

11.1. Efforts should be made to inform the hiring agency's administrators about the strengths and limitations of pre-employment psychological evaluations.

11.2. Pre-employment psychological evaluations should be used as one component of the overall hiring process.

11.3. Care should be taken when using pre-employment test results for purposes other than making pre-employment decisions.

11.4. The hiring agency should not use the pre-employment evaluation for promotional evaluations or for positions not expressly considered by the psychologist at the time of the evaluation.

12. Follow-Up

12.1. Continuing collaborative efforts by the hiring agency and evaluating psychologist should be made to assess the accuracy of the final suitability determination. Follow-up data should be collected in accordance with strict confidentiality provisions protecting individual applicant identities and in accordance with ethical research guidelines and the law.

12.2. The psychologist and/or hiring agency should evaluate whether final suitability ratings have an adverse impact on protected classes of candidates.

12.3. Psychologists should be prepared to defend their procedures, conclusions, and recommendations if a decision based on psychological evaluation results is challenged.

13. Appeals and Second Opinions

13.1. Hiring agencies that permit second-opinion evaluations as part of an appeal process should require that these psychological evaluations be based upon the same criteria used for the initial psychological evaluation.

Officer-Involved Shooting Guidelines

Ratified by the IACP Police Psychological Services Section
Philadelphia, Pennsylvania, 2013

1. Purpose

1.1. It is widely accepted that officers involved in shootings or other significant critical incidents require immediate support.[1] The goal of these guidelines is to provide recommendations to public safety agencies, and the mental health providers who provide the service, to prepare and respond to the health and well-being of law enforcement personnel following an officer-involved shooting. The Guidelines were developed not to provide a rigid protocol but to offer information and recommendations to public safety agencies and their mental health providers that can be flexibly applied in response to the complex demands that may vary across jurisdictions following these incidents. Many of these recommendations are not only applicable to officer-involved shootings, but also other potentially distressing critical incidents and help to identify and assist those individuals at higher risk for experiencing and/or developing resultant mental health problems. Decades of experience by police and public safety mental health professionals, along with scientific research, suggest that following these guidelines can promote positive outcomes following such incidents.

2. Limitations

2.1. The term "guidelines" in this context refers to recommended procedures for agencies. Guidelines are not mandatory; they are aspirational in intent. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every situation. They are not definitive, and they are not intended to take precedence over the judgment of the agency or their mental health provider. Each of the guidelines may not apply in a specific case or in all situations. The decision as to what is or is not done in a particular instance is ultimately the responsibility of the agency.

3. Pre-Incident Preparation

3.1. Officers and agencies, and all those involved in investigating and making official determinations about officer-involved shootings, should become educated about the science of human performance factors[2] that influence behavior during high stress, time pressured, deadly force confrontations.

3.2. Command and line staff should be made aware of the residual emotional, psychological, and behavioral effects often associated with officer-involved shootings and other potentially distressing critical incidents. Agencies are encouraged to train all their personnel in both normal and problematic posttraumatic reactions and appropriate ways to respond to employees who have been involved in a traumatic incident. Training should include what to expect personally (including the effect on family members), professionally, departmentally, and legally after a shooting or other significant use-of-force incidents. Such training may occur as part of the initial academy training and/or as part of the department's ongoing in-service training program. The training material should be made widely available to personnel to use as reference material in the event they become involved in a deadly force or other critical incident.

3.2.1. As part of the agency training, personnel should be made aware of specific counseling options offered by their agency, when available, for both the involved officers and their families following an officer-involved shooting or other critical incident.

3.3. Prior to any shooting incident, it is recommended that the agency establish a working relationship with one or more qualified, licensed mental health professionals experienced in the law enforcement culture as well as in the provision of post-shooting or other critical incident interventions. The department should notify this mental health resource as soon as possible following an officer-involved shooting or other critical incident, so that an appropriate intervention can be facilitated in a timely fashion.

3.4. Agencies should consider developing a roster, with timely updates, containing the names and contact numbers of family members and significant others whom such personnel would like to have notified in the event that they are injured on duty and are unable to contact them personally. Officers should also identify two or three fellow officers, in order of preference, whom they would like to have contact their family or significant other when feasible if they are unable to personally make contact after a shooting or comparable critical event. Agencies should take steps to help prevent this information from being viewed by unauthorized personnel, and yet is readily available at the time of an incident. While it is preferable to have contact made by an officer who is known to family members, this may not be feasible and agencies should ensure that contacts with

family and significant others is made by personnel trained to make such notifications.

4. At the Scene and Immediately Following

4.1. Immediately after an officer-involved shooting or other critical incident, involved personnel should be provided physical and psychological first aid (e.g., emotional support, reassurance to involved personnel, assignment of a companion officer to any officer who is directly involved in a shooting and is separated from others pending investigative procedures). This support should be focused on calming physical and emotional stress and restoring and/or reinforcing the officers' sense of safety.

4.1.1. Inasmuch as officers who did not fire their weapons are often overlooked in the aftermath of a shooting event, agencies should be mindful that "involved officers" may include not only those who fired their weapon, but also officers who were at the scene and either did not, or could not, fire their weapon. Such officers are often strongly impacted. It is possible that similar reactions by such officers may also take place following other critical incidents. This is not intended to expand the scope of rights that witness officers may or may not have with regard to the investigation, but should be strongly considered in providing support and mental health assistance to all "involved" personnel.

4.2. After providing needed public safety information, officers who fired a weapon or were directly involved in a critical incident should be encouraged to step immediately away from the scene and be transported to a safe and supportive environment by a trusted peer or supervisor. To ensure officers are not isolated once transported from the scene, whenever possible the agency should ensure there is a companion officer of the officer's choice, a chaplain, or a supportive peer available. Often the best support person is a fellow officer who is trained in peer support (see *IACP PPSS Peer Support Guidelines)*, or has previously gone through an officer-involved shooting, who can be assigned to the officer immediately following the incident. If officers have an immediate need to talk about the incident, they should be encouraged to do so solely with individuals with whom they have privileged communication (i.e., attorney, chaplain, licensed mental health professional, and in some states, trained peer support personnel).

4.3. Following a shooting incident, officers often feel vulnerable if unarmed. If an officer's firearm has been taken as evidence or simply pursuant to departmental policy, a replacement weapon should be immediately provided as a sign of support, confidence, and trust unless there is an articulable basis for deviating from this procedure. Officers should be kept informed of when their weapon is likely to be returned. Care should be taken to process and collect evidence from the officer as soon as practicable to provide an opportunity to change into civilian clothing.

4.4. Officers involved in a shooting or other critical incident should be provided with the opportunity and encouraged to personally contact their family members as soon as possible after the incident (e.g., by cell phone while being transported from the scene). Timely personal contact may reduce the likelihood of loved ones receiving incomplete or misleading information from the media or other forms of rapid electronic communications. It is prudent that no contact be made with family members before the officers have had this opportunity. Officers should be instructed to limit information to their well-being and not the facts of the incident. If it is not feasible to call themselves, then individuals who preferably know the families, or have been previously chosen by the officers (see 3.4), or have notification training, or are designated by the department, should call as soon as possible. Offers to call other support people such as friends, family members, chaplains, qualified mental health professionals, and so on, should be made to ensure that the family members have their support system mobilized. Family members who wish to be with injured officers should be offered transportation in lieu of driving themselves.

4.4.1. Officers not involved in the incident, but on duty at the time of the incident, should be allowed, as time permits, to contact their families and advise them that a shooting or other critical incident has occurred, but that they were not involved (or injured).

4.5. The investigative process and concerns over legal and administrative consequences are often the most stressful parts of an officer-involved shooting or other critical incident for involved personnel. The first few hours after a shooting or other critical incident is a potentially emotional and confusing time so officers may wish to consult their union and legal counsel. Whenever possible, officers should be educated on the protocol of the investigation as well as any potential actions by the media, grand jury, or review board prior to any formal investigative

interviews. It is equally important that, over time, officers be made aware of the progress of the investigation in a timely fashion.

4.5.1. Administrators, peers and legal advisors having contact with involved personnel should remember that what they say to an officer immediately after a shooting or other critical incident may be long remembered.

4.6. Following a shooting or other critical incident, it is helpful to provide officers and their significant others with written information that explains physical and psychological reactions to shooting or other critical incidents. Topics covered should include what to expect psychologically and physically, how to support each other, coping strategies, resiliency strategies, and identifying whom to contact for further assistance.

4.6.1 Due to the overwhelming presence of social media, involved officers should be reminded of the risks to their presence on social media, as there may be unwanted others viewing their comments/postings/blogs. They should further be reminded that viewing media and/or community negativity through television and web-based postings may complicate post-incident thoughts and emotions.

5. Investigative Period

5.1. Shootings and other critical incidents can result in heightened physical and emotional reactions for the participants that require a brief respite from work to marshal natural coping skills and manage the emotional impact of the incident prior to a return to duty. Consequently, agencies should develop a policy that addresses post-incident time off before an officer's return to his or her pre-incident assignment. Crafting such departmental policies for individuals involved in shootings and other critical incidents should be done with some flexibility in that some officers may be minimally impacted and may find prolonged leave counterproductive while others may require more time off. For those officers directly involved in a death or serious injury to another person, a minimum of three days leave, using either administrative leave or regular days off, should be granted. Agencies should also be mindful of those personnel who were present at the scene but, for example, did not discharge their weapons, as they are frequently emotionally impacted by the incident and may, in some cases, benefit from a period of administrative leave. It is important that officers and the public

understand that administrative leave is a routine procedure and not a disciplinary suspension.

5.2. While officers may be asked to provide pertinent information soon after a shooting to aid the initial investigative process, whenever feasible, officers should have some recovery time before providing a full formal statement. Depending on the nature of the incident, the demands on the agency, and the emotional and physical status of the officers, this can range from a few hours to several days. An officer's memory will often benefit from at least one sleep cycle prior to being interviewed leading to more coherent and accurate statements.[34567] Providing a secure setting, insulated from the press and curious coworkers, is important during the interview process.

5.3. Talking with trained peers who have had similar experiences can be quite helpful for officers involved in deadly force and other critical incidents. Often these personnel respond immediately on scene to provide support and psychological first aid. Trained peer support personnel may also be an asset by participating in post-incident group interventions in conjunction with a mental health professional trained and experienced in working with law enforcement. Family members of officers involved in shootings may also benefit from contact with a trained mental health professional and/or peer support, particularly from the family members of those who have previously been involved in shootings or other life-threatening events. The formation and administrative backing of peer support and outreach teams for officers and family members may prove to be a wise investment prior to an officer-involved shooting and other critical incidents. Only peer support team members who have received specialized training in crisis intervention and the rules of confidentiality promulgated by the department should be utilized. Peer support should only be ancillary to intervention by a mental health professional trained and experienced in law enforcement and officer-involved shootings or other critical incidents and should never take its place. (Please see *IACP PPSS Peer Support Guidelines* for information concerning the development and use of peer support teams.)

5.4. Timely communication from high-ranking administrators of their personal concern and support for officers involved in significant use-of-force and other critical incidents can provide an extra measure of reassurance and comfort. The administrator does not have to comment on the situation, or make further statements regarding legal or departmental resolution, but can show concern and

empathy for the officers during this stressful experience. These contacts, whether in person or via telephone, should be made as soon as possible after the incident.

5.5. To promote the dissemination of accurate information and quell unfounded rumors, as soon as practicable and to the extent allowed, a designated and informed person should brief the officers' supervisors and unit, followed by the agency as a whole, about the shooting and other critical incidents. Efforts should be taken to ensure distributed information is accurate. Furthermore, agencies should make every effort to expedite the completion of administrative and criminal investigations, keeping the officers informed in a timely manner, and notifying officers of the progress and outcome as soon as possible.

5.6. Significant use-of-force investigations are complex events and may involve an array of law enforcement and other government agencies. Continued communication among all parties throughout the course of an investigation protects involved officers by mitigating misunderstandings and conflict among the different interests and concerns.

5.7. Members of the community, including the media, would benefit from education regarding procedures, protocols, and human performance factors related to police use of force, especially deadly force encounters. It is recommended that police agencies assist these community education efforts by providing information about factors involved in police use of deadly force including officer safety issues and pertinent laws.

5.8. Unnecessarily lengthy investigations cause undue distress to officers. Agencies should make every effort to expedite the completion of administrative and criminal investigations. Departments that do not conduct their own criminal investigations and cannot control the length of time required to complete the investigation should meet with the investigating agency and prosecutor before a shooting and other critical incident occurs to work out the logistics in advance. While investigations are pending, supervisors should maintain regular contact with officers and keep them apprised of any pertinent developments.

6. Post-Shooting Interventions

6.1. Post-shooting and other critical incident interventions should be conducted only by licensed mental health professionals trained and experienced in working with law enforcement personnel and familiar with officer-involved shootings and other

critical incidents. Care should be taken in selecting a mental health professional to ensure that he or she is well versed in the normal range of human reactions to critical incidents, and is competent in the education and treatment of trauma in a law enforcement population.

6.2. Some officers would choose not to participate in the post-shooting interventions provided by qualified mental health professionals, yet when required to participate, they often find it helpful.[8] In addition, some may be unaware of the potential impact of the incident and/or be sensitive to the stigma of seeing a qualified mental health professional, thus choosing not to participate. For these reasons, it is recommended that officers be required to participate in one individual post-shooting (or other critical incident) intervention with a qualified mental health professional so they can, at a minimum, be provided with basic education and coping skills to better manage their reactions. This does not mean that it should be mandatory for them to discuss the event with the mental health professional. Participation in the initial session is driven by the nature of the event, not the attribution of a manifest problem by the officer, and it should be emphasized that this session is not a disciplinary action. Any participation beyond attendance of the first session should be voluntary on the part of the officers.

6.3. After a life-threatening incident, officers are often concerned about how they reacted physiologically and emotionally, and whether these reactions were "normal." Post-shooting and other critical incident interventions should be primarily educative as this reassurance reduces worry, anxiety, and negative self-assessment. Much of the time, the normalization and education provided during the post-shooting and other critical incident intervention regarding common changes to perception, attention and memory[9] affords sufficient support to facilitate resilience and individual coping abilities. If not adequately addressed, however, these reactions may lead to more severe and chronic problems requiring treatment services.

6.4. The initial post-shooting and other critical incident intervention should occur within one week after the shooting incident. The initial goal should be to reduce stress, assess and "normalize" any problematic post-incident reactions, and provide education regarding the management of any problematic post-incident reactions. Particular attention should be paid to maintaining sleep functioning, accessing social support, and avoiding excessive alcohol use. Officers should be

assisted in preparing themselves and their loved ones for inaccurate, negative or inflammatory comments in the media, including TV, print media, and the Internet.

6.5. It is recommended that officers not be required to return to work immediately following a post-shooting or other critical incident intervention session.

6.6. A single contact with a mental health professional may prove to be inadequate for officers who have been severely affected by a shooting or comparable event. Also, some officers may experience delayed onset of problems. The qualified mental health professional should informally assess, for the sole purpose of a voluntary referral, which officers may need additional or alternative types of support to further their recovery process. Follow-up sessions should be made available to every involved officer and, if appropriate, voluntary referrals may be offered for counseling and/or to peer support or chaplaincy programs.

6.7. Because delayed reactions may occur, all officers receiving an initial post-shooting and other critical incident intervention should receive follow-up contact by the mental health professional either via phone or e-mail sometime within the first month, and at four months post-incident. In addition, contact should be made prior to the first anniversary of the incident (and the potential for anniversary reactions should be discussed in the initial intervention).

6.8. It should be made clear that the individual post-shooting intervention is a confidential communication between the mental health professional and the officer involved. No information about the content of these sessions should be released without the officer's written authorization. The usual legal exceptions to confidentiality should be explained to all participants, including whether or not the confidentiality is legally privileged. The mental health professional should include an informed consent process before the intervention commences that contains a description of the possible benefits and risks of the intervention. In the case of an agency-required intervention, it should include a statement giving the mental health professional limited permission to verify the officer's attendance at the intervention session to the agency without revealing any further details of the intervention.

6.9. Life-threatening use-of-force and other critical incidents also have the potential to emotionally impact an officer's family and significant others, who often can provide valuable support to officers following these incidents. As long as confidentiality and privilege can be maintained, it can be beneficial for all

concerned to include such family members and significant others in the post-incident intervention process. If family members or significant others are invited, officers may have specific preferences about individual versus joint sessions, and mental health providers should give serious consideration to such preferences. The decision to conduct individual interventions followed by joint interventions, or joint interventions alone, should be decided by the officer and mental health provider.

6.10. It should be made clear to all involved personnel, supervisors, and the community at large that officers' fitness-for-duty should not be brought into question simply by virtue of their involvement in a shooting or other critical incident. Post-shooting and other critical incident psychological interventions are separate and distinct from any fitness-for-duty assessments or administrative or investigative procedures that may follow. This does not preclude an agency from requesting a formal fitness-for-duty evaluation based upon objective concerns about an officer's ability to perform his or her duties due to a suspected medical or psychological condition. However, the mere fact of being involved in a shooting does not necessitate such an evaluation prior to return to duty. (Please see *IACP PPSS Psychological Fitness-for-Duty Evaluation Guidelines* for information concerning the criteria and procedures for these evaluations.)

6.11. If a fitness-for-duty evaluation is requested, it should not be conducted by the mental health professional who provided the post-shooting intervention, or any other post incident counseling. However, as part of the post-shooting intervention, the mental health professional can assist officers in making decisions concerning returning to duty.

6.12. Group psychological interventions may be beneficial following incidents involving multiple personnel. All officers directly involved in the shooting incident should receive an initial individual intervention prior to the group session. Participants should be limited to persons who were involved in the event and attendance should be strictly voluntary but encouraged. Additional individual counseling referrals should be available and encouraged for those needing or wanting further assistance. Agencies should also consider the impact of deadly force and other critical incidents on all other involved emergency service personnel (e.g., dispatchers) and provide appropriate interventions consistent with these guidelines.

6.13. Group sessions may be jointly facilitated by one or more mental health professionals experienced in working with law enforcement and trained peer support personnel. The confidentiality of group sessions should be respected and some jurisdictions provide a degree of legal privilege to sanctioned peer support groups. Regardless of local laws, when information is processed in group settings, the risk of a breach of confidentiality is greater than in individual sessions conducted by licensed mental health professionals with whom officers have legal privilege. Although it is recommended that attendance at group sessions be voluntary, if attendance is mandated, any participation should be at the discretion of each officer (see 6.2).

Appendix D

Endnotes

[1] Best, S., Artwohl, A., & Kirschman, E. (2011) Critical Incidents in *Handbook of Police Psychology*, ed. Jack Kitaeff (New York: Routledge, Taylor and Francis Group, 2011), 491–507.
[2] Honig, A., & Lewinski, W.J. (2008). A survey of the research on human factors related to lethal force encounters: Implications for law enforcement training, tactics and testimony. *Law Enforcement Executive Research Forum*, 8(4), 129-152.
[3] Geiselman, R. E. (2010). Rest and eyewitness memory recall. *American Journal of Forensic Psychology*, 28(2).
[4] Diekelmann, S., Landolt, H.P., Lahl, O., Born, J., & Wagner, U. (2008). Sleep Loss Produces False Memories. *PLOS ONE*, 3 (10).
[5] Ellenbogen, J.M., Hulbert, J.D., Stickgold, R., Dinges, D.F., & Thompson-Schill, S.L. (2006). Interfering with Theories of Sleep and Memory: Sleep, Declarative Memory, and Associative Interference, *Current Biology*, July 2006.
[6] Stickgold, R., and Ellenbogen, J.M. (2008). Quiet! Sleeping Brain at Work, *Scientific American Mind*, August/September 2008, 19(4), 22-29.
[7] van der Helm, E., Gujar, N., Nishida, M., & Walker, M. P. (2011). Sleep-dependent facilitation of episodic memory details. *PLOS ONE*, 6(11): e27421.
[8] Honig, A., & Sultan, S. (2004). Reactions and resilience under fire: What an officer can expect. *The Police Chief*, 71 (12), 54-60.
[9] Artwohl, A. (2002). Perceptual and memory distortions in officer-involved shootings. *FBI Law Enforcement Bulletin*, 71 (10), 18-24.

Appendix E

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M E M O R A N D U M

August 29, 2014

TO: Representative Jonathan Singer

FROM: Conrad Imel, Research Analyst, 303-866-2756

SUBJECT: State Policies to Prevent Officer Mental Health Issues

Summary

This memorandum responds to your request for information regarding state programs for preventing Posttraumatic Stress Disorder (PTSD) following traumatic incidents and designed to prevent mental stress disorders from becoming worker's compensation cases. This memorandum provides a brief overview of PTSD and Critical Incident Stress Management programs designed to treat mental trauma; discusses state and departmental programs; and provides examples of organizations dedicated to law enforcement officers' mental health.

Overview

Posttraumatic Stress Disorder (PTSD) is a delayed psychological response to an extreme situation or event. Generally, PTSD is thought of in relation to wartime and soldiers, but recently PTSD among non-war-related professions has gained recognition. This recognition has led state and local government employees to file workers' compensation claims for PTSD. The outcome of many of these claims is determined in court because most states do not have statutes that cover PTSD in workers' compensation programs. One state, Minnesota, specifically covers PTSD as a occupational disease under workers' compensation.[1] Other states offer compensation for mental trauma that arise from unusual or sudden incidents.

[1] Minn. Stat. § 176.011, *et seq.*

PTSD is one diagnosis among many that may be made following a traumatic event. Instead of focusing on PTSD specifically, states and law enforcement agencies that act to prevent mental injuries may establish Critical Incident Stress Management (CISM) programs. CISM programs promote pre-event stress and crisis management education; planning and policy development; and training and preparation for the management of traumatic stress. CISM programs also provide peer and professional counseling and debriefings after traumatic events. State and department CISM programs are discussed below.

State Laws and Policies

Staff did not identify any state laws or policies specifically designed to address PTSD in police officers and prevent workers' compensation cases; however, a few states have passed laws to establish and fund programs to help officers facing difficult mental issues. In general, the state laws tend to be very broad, allowing for agencies to administer mental health programs. Many of the programs identified follow the same general tenants of a CISM program: training and education, peer support, and debriefing following a traumatic event.

New Jersey. New Jersey established the "Law Enforcement Officer Crisis Intervention Services" telephone hotline.[2] The hotline, named Cop-2-Cop, was established to assist law enforcement and sheriff's officers "who have been involved in any event or incident which has produced personal or job-related depression, anxiety, stress, or other psychological or emotional tension, trauma, or disorder." Cop-2-Cop offers peer and clinical support, clinical assessments, and CISM services. Additionally, in 2014, New Jersey passed a law to protect as confidential communication between a peer counselor and any emergency services personnel in an emergency assistance program.[3]

South Carolina. The South Carolina legislature created the South Carolina Law Enforcement Assistance Program (SC LEAP) to provide counseling services to law enforcement officers and their families.[4] SC LEAP is authorized to utilize chaplains, mental health professionals, and law enforcement peers and the program's website claims that its staff and volunteer chaplains are available 24 hours per day, seven days per week. The enacting statute specifically requires support following deaths or other tragic incidents involving officers, but SC LEAP also offers other programs, including CISM training, suicide intervention, suicide prevention training, and alcohol rehabilitation services.

Nebraska. Nebraska's legislature has established the Critical Incident Stress Management Program.[5] Like those discussed above, Nebraska's program offers stress management assistance and emotional and educational support to emergency service personnel (defined in the act to include law enforcement personnel, firefighters, emergency medical services personnel, and hospital personnel). The program is overseen by the Critical Incident Stress Management Council, which is made up of representatives from the Department of Health and Human Services, the State Fire Marshal, the Superintendent of Law Enforcement and Public Safety, and the Adjutant General as director of the Nebraska Emergency Management Agency. The council provides the overall policy direction and operational goals for the program. The program is administered by a committee made up of representatives from the council members' agencies. Additional state agencies provide counseling and support for the program.

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[2]N.J. Rev. Stat. § 26:2NN-1; www.cop2coponline.com.

[3]N.J. Rev. Stat. § 2A:84A-22.17.

[4]S.C. Code Ann. § 23-3-65; www.scleap.org.

[5]Neb. Rev. Stat. § 71-7101, *et seq.*

Alternatives to statutory CISM programs. Many states promote stress management for officers in ways other than statutorily created programs. For example, states may provide protection for local or independent programs by granting statutory confidentiality or privilege to the communications made within those programs.[6] Others only grant privilege to communications made while participating in specific non-governmental stress management programs.[7] Finally, some states instruct departments to create plans for CISM programs. In Virginia, the legislature has charged the Board of Health to prepare a Statewide Emergency Medical Services Plan which includes maintaining a CISM program.[8] Additional information about any specific state program is available from staff upon request.

Department Policies

Many individual departments have created their own CISM programs independent of state action. These programs are similar to the state CISM programs outlined above; they consist of counseling and education to support agency employees who have experienced a traumatic incident. Like state programs, department programs do not indicate preventing workers' compensation claims as a purpose of the program. Selected department programs are discussed below.

Richmond, Virginia. The Richmond (Virginia) Police Department maintains its own CISM team, not shared with other law enforcement agencies.[9] The CISM team is comprised of sworn and civilian police department personnel, social services personnel, chaplains, and mental health professionals. The team uses techniques common among CISM programs, such as peer support and education. The program does not specifically seek to prevent workers' compensation cases, but does claim the CISM team will assist in returning workers to duty faster and healthier.

Great Falls, Montana. The CISM program in Great Falls, Montana, is structured like many other programs, even though Montana does not require or define CISM programs.[10] Great Falls' program is not limited to police officers; instead, many different associations have joined together to create the CISM program. The CISM team includes members from the police and fire departments, the 9-1-1 Emergency Dispatch Center, Malmstrom Air Force Base, the United States Marshals Service, and mental health professionals.[11]

Phoenix, Arizona. While many law enforcement or other government agencies establish and maintain CISM programs, the City of Phoenix has contracted with a third party, MHN, to

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[6]Examples include: Arizona (Ariz. Rev. Stat. § 38-1111); Delaware (Del. Code tit. 10, § 4319); Missouri (Mo. Rev. Stat. § 191.1112); Montana (Mont. Code Ann. 39-74-101, *et seq.*); and Texas (Tex. Health & Safety Code § 784.001, *et seq.*).

[7]Tennessee statutes recognize critical stress management teams trained by "the International Critical Incident Stress Foundation, the National Organization for Victim Assistance, the American Red Cross, the Tennessee Public Safety Network and other such organizations" (Tenn. Code Ann. § 24-1-204 (a)(4)). Arkansas statutes only recognize peer support staff trained and certified by the Arkansas Crisis Response Team, a volunteer organization. Ark. Code § 16-40-106; www.arcrt.org.

[8]Va. Code Ann. § 32.1-111.3 (A)(13).

[9]Critical Incident Stress Management Team, Richmond, Virginia; www.richmondgov.com/Police/CISM.aspx.

[10]Montana does not mandate CISM programs, but does encourage critical incident stress management and provides statutory protection for information provided during CISM and response services (Mont. Code Ann. § 39-74-101, *et seq.*).

[11]Critical Incident Stress Management (CISM), Great Falls, Montana website; www.greatfallsmt.net/police/critical-incident-stress-management-cism.

provide CISM services.[12] MHN offers the same general services as other CISM programs, such as debriefing and counseling. Like government-run programs, MHN does not state the goal of preventing workers' compensation claims, but does promote helping employees to return to work.

Colorado. In Colorado, HealthONE EMS provides crisis support to emergency responders and hospital personnel through its Colorado Crisis Network.[13] The Colorado Crisis Network consists of eight teams that cover different regions of the state. For example, the Mayflower Crisis Support Team covers the Denver metro area and eastern areas of the state by utilizing a network of EMS, fire department, law enforcement, and nursing staff; ski patrol; search and rescue; victims advocates; and mental health professionals.[14] The Mayflower team is a volunteer organization and does not charge for its services, which include education, debriefings, and interventions similar to other CISM programs.

National Organizations

There are not-for-profit organizations, for-profit third-party CISM providers, and police officer suicide prevention organizations that provide information on CISM programs. The International Critical Incident Stress Foundation is a resource for information, including information on critical incident stress in general, and CISM programs in particular.[15] The federal Occupational Health and Safety Administration (OSHA) also provides information and references on CISM, even though OSHA does not have specific standards covering mental stress, such as PTSD, after traumatic incidents.[16]

CISM International is a for-profit organization that offers CISM training programs to businesses.[17] CISM International claims many benefits come from its programs, including reducing litigation, preventing worker injuries and errors and their associated costs, promoting employee wellness, and decreasing utilization of sick time and benefits. Among the various policies and programs reviewed by staff, CISM International was the only organization that highlighted the financial benefits of CISM programs.

Finally, there are many organizations focused on preventing police officer suicide, and consequently work to prevent PTSD. CopsAlive is operated by the Law Enforcement Survival Institute.[18] CopsAlive provides information and resources encouraging police wellness and suicide prevention, including raising awareness of PTSD. Catch a Falling Star offers assistance programs for law enforcement and their families that are members of the organization.[19] Additionally, many police departments offer suicide prevention materials and support.

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[12] Critical Incident Stress Management, Phoenix Law Enforcement Association, http://azplea.com/about-plea/affiliations/cism; Critical Incident Stress Management (CISM), MHN, A Health Management Company; www.mhn.com/content/critical-incident-stress-management-cism.

[13] Colorado Network Resources, HealthONE EMS; www.healthoneems.com/conetwork.html.

[14] Mayflower Crisis Support Team, HealthONE EMS; www.healthoneems.com/mayflower.html.

[15] www.icisf.org.

[16] Critical Incident Stress Guide, Occupational Health and Safety Administration; www.osha.gov/SLTC/emergencypreparedness/guides/critical.html.

[17] www.criticalincidentstress.com.

[18] www.copsalive.com; www.lawenforcementsurvivalinstitute.org.

[19] www.catchafallingstar.net.

Appendix F

PEACE OFFICER PTSD TASK FORCE
ADVISORY POLICY SUB-COMMITTEE REPORT

Report Overview

This summary report utilized a GAP ANALAYSIS format which focused on three areas for trauma awareness, mitigation and recovery:

1. Pre-Event Horizon---The phase before an officer has experienced trauma exposure
2. Event Horizon---The phase when the officer has either experienced acute or long term trauma exposure
3. Post Event Horizon---The phase in which the officer has either developed PTSD or is experiencing significant traumatic reactions due to intrusions and flashbacks.

Each of these phases were analyzed according to the Issues and Challenges present at each time segment, Gaps between Issues and available Programs and Countermeasures to mitigate the Gaps

Notable Survey Results

In a recent survey of Colorado chiefs, sheriffs, and command staff in the State patrol, as well as DOC:

- Only 53% stated their agency has trauma-related training
- 70% denied having a Peer Support program (that they knew of)

A second survey for law enforcement officers, field ops, detentions, and corrections officers:

- 98% experienced an event considered traumatic
- Between 15% (hallucinations or reliving) and 70% (fear, hopelessness) experienced various symptoms of PTSD
- After the incident, only 26% saw a psychologist or psychiatrist.
- 44% received trauma-related training during the Academy

Pre-Event Horizon

Issues

1. Recruits and new LEOs unaware of Impact or Vicarious Trauma Triggers
2. Recruits and new LEOs unaware of early trauma symptoms
3. LEOs needing Inoculation Training
4. Academy Curriculum filled up with other training topics
5. Department Policies and Procedures
6. Limited Resources

Gaps

1. Only 53% of the respondents in one survey indicated that their agency had trauma-related training. A second survey indicated that only 44% of the Departments provided trauma-related training during the Academy.
2. Departments have not conducted or developed policies, procedures or protocols for assignments or events that can potentially produce a traumatic response (child porn assignments, mass casualty events, etc.).

3. Departments may not have available Subject Matter Experts (SMEs) to assist in the Inoculation process.
4. Some departments may not have contracts in place for CISM response.
5. Smaller departments may not have resources for Peer Support.
6. Many critical incidents cannot be planned.

Countermeasures

1. Training
    a. Academies and Continuing Education courses should be required on trauma awareness, including vicarious trauma, and inoculation. How to respond tactically as well as psychologically may be included during scenarios and didactics as a well to inoculate recruits and officers.
    b. Spouse academies and trainings should also include information on vicarious trauma and symptoms.
    c. For officers being assigned to a high-intensity assignment, such as child pornography, extra attention should be paid to providing information on vicarious trauma, signs of stress, and policies should be in place to help in reducing stress (i.e. limited overtime, recommending breaks and regular exercise, self-care, etc.).
    d. Sergeants and commanding officers should receive training on noticing signs of stress and trauma, and should be equipped with resources including Peer Support and EAP.
    e. As technology continues to advance, academies and continuing education curriculum may benefit from simulations that utilize virtual reality for stress inoculation, similar to what the military does in immersion training for soldiers. This allows them to experience a critical incident in a safe environment and allows for both tactical and emotional response practice.
2. Resource Development
    a. Psychological Services either internal or external
    b. Peer Support

Event Horizon

Issues

1. TOO MUCH TOO UGLY TOO SOON
2. TOO MUCH TOO UGLY TOO LONG
3. TOO MUCH TOO UGLY TOO SIMILAR OR TOO DIFFERENT
4. Lack of recognition of trauma from the department
5. Awareness but lack of insight from the LEOs
6. LEOs engaging in denial

Gaps

1. There are guidelines for officer-involved shootings (IACP, 2013) but not for other incidents that may cause trauma reactions, such as cases involving children (abuse, kidnapping, pornography).
2. LEOs reaching out for help, but no skilled resources available
3. Stigma around seeing EAP or Peer Support following a critical incident
4. Social media has become more prevalent, and officers often overlook the impact.

Countermeasures

1. Departments should follow the IACP Guidelines for Officer-Involved Shootings (2013). Some guidelines include: Immediate psychological first aid (usually from Peer Support), connection with Peer Support and/or another officer who has previously experienced something similar to help normalize reactions, and follow-ups from a mental health professional at both one and four months post-incident.
2. Peer Support
    c. Ensure officers are aware of Peer Support, and ensure that Peer Support maintains visibility throughout the department (i.e. occasional e-mail reminders, posters). Ensure understanding of departmental policy regarding confidentiality of Peer Support.
    d. Ensure adequate training for members of Peer Support and provide them with appropriate referrals and resources.
    e. For agencies unable to have a Peer Support program due to lack of funding or size, Mutual Aid or a Regional Peer Support Program would be beneficial.
3. Psychological Services
    a. Each department should have an EAP. Ideally, there would be clinicians in the EAP with specialized training and knowledge of law enforcement and trauma.
    b. EAP should maintain visibility so officers know how to contact them. If an officer is experiencing high stress levels in his/her everyday life, he/she may be more likely to experience more severe trauma reactions following a critical incident.
    c. Departments should have contracts with an agency or group to provide psychological interventions following a critical incident.
4. Larger scale incidents (i.e. Century 16 shooting) will require both Peer Support and CISM onsite during the incident. In cases where there are multiple departments and agencies responding, there should be a clear chain of command and limited access credentialing for outsiders attempting to help.
5. Departments should consider assessing any critical incident, regardless of whether a weapon is fired, for the need for psychological intervention.
6. Officers involved in high intensity assignments should have regular wellness checks, and this should be part of departmental policy. Wellness checks would be appropriate annually with additional meetings as needed.
7. Peer Support should be utilized to help identify officers who may need additional help and facilitate them connecting to the appropriate resources.

8. Command staff, Peer Support, and/or Psychological Services should caution officers that there will be articles, blogs, and comments on social media that may trigger an emotional response (anger, sadness, etc.).

Post Event Horizon

Issues

1. According to the survey 15% of the LEOs that experienced a traumatic event developed significant symptoms and 70% reported lower level trauma symptoms.
2. The disorder lasts longer than the coverage or resources
3. Public and Departmental concerns of malingering
4. Delayed reactions
5. Reactivation of symptoms due to triggering events (anniversaries, long trials, similar events)
6. Lack of ongoing services and coverages

Gaps

1. PTSD is currently viewed as part of the job as opposed to an injury resulting from an incident.
2. The LEOs perception that their identity and personal information can not necessarily be kept confidential.
3. IMEs not SMEs in either law enforcement or trauma

Countermeasures

1. Policies should include PTSD as eligible for workers compensation claims.
2. Mental health practitioners who were involved in the psychological intervention should follow up with officers at both one- and four-month intervals post-incident, as delayed reactions can occur.
3. Follow-ups should also occur on anniversaries, especially of larger scale incidents, and during any meaningful times during trial (i.e. public release of response report, mistrial, etc.).
4. Have Peer Support members monitor officers as media reports arise, as this sometimes includes inaccurate information that may trigger a response, or create negative public opinion.
5. Departments should be judicious in the disclosure of personal information of officers to the public and understand the potential risks. IACP OIS Guidelines (2013) suggest waiting at least 48 hours. The officer should be informed beforehand so they have time to both process and make any security decisions.
6. IMEs should be required to have skill sets in both trauma and law enforcement job duties.

Appendix G

Peace Officer PTSD Task Force Legislative Subcommittee Meeting

November 5, 2014
2 p.m. – 4 p.m.

Attendees:

Representative Jonathan Singer

Colorado State Patrol
Lt. Colonel Brenda Leffler

Department of Corrections
Rick Thompkins, Chief of Human Resources

County Sheriffs of Colorado
Sheriff Joseph D. Hoy, Eagle County

Dept. of Personnel and Administration
Markie Davis, Manager

Dept. of Personnel and Administration
Jack Wylie – Legislative Liaison

Colorado Bar Association
Paul N. Fisher, Attorney – CBA Military & Veterans Liaison

Colorado Psychiatric Society
George Hartlaub, MD

The legislative subcommittee came to order at approximately 2:05 p.m.

The subcommittee discussed the following issues that were brought forth from the primary PTSD Task Force discussion:

1. Examine the definition of "PTSD", "injury" and "disease" that were included in the original bill and make recommendations for revisions.

Recommendation: "PTSD" should be defined with either the most current version of the DSM or the version of the DSM that has been accepted by the Colorado Division of Workers' Compensation.

2. Determine if there needs to be a definition and application of "on-duty" versus "off-duty".

Recommendation: Off-duty incidents should be covered the same as on-duty incidents. Worker's Comp and insurance already cover officers acting under the color of authority, while off duty.

3. Review other state statutes for potential inclusion in Colorado legislation.

Recommendation: Legislative Council conducted extensive research and did not identify any single solution from another state. Rather, the research demonstrates that any legislative solution should be

combined with non-legislative alternatives. The subcommittee recommends replicating South Carolina's program in some manner in Colorado.

4. Provide any additional recommendations, as necessary.

The subcommittee provided several other legislative and non-legislative recommendations, to include:

- An objective of the PTSD Task Force report should be to ensure employees who are exposed to traumatic events on the job or who act under the color of their authority in an off-duty incident have access to the Worker's Comp system. The subcommittee recommends that any solution include all employees and that an exemption not be carved out for law enforcement and corrections officers.

- The current Worker's Comp statute should be modified to ensure consistency in application. The "outside of normal experience" language is difficult to interpret and apply consistently. The statue already addresses claims in disciplinary actions, terminations, and other situations that could encourage abuse by employees, therefore it is not necessary to address this issue specifically.

- As opposed to limiting treatment options with the narrow term, "PTSD," the term "mental impairment", of which PTSD is a subcategory, should be used. Otherwise, employees may not receive adequate care and may try to fit their symptoms and issues into a PTSD diagnosis in an attempt to get help for anxiety, depression or similar disorders.

- There should be a focus on early identification and treatment, particularly in cases of cumulative PTSD.

- A media campaign should be considered to bring awareness to PTSD, suicide and other mental impairment issues, particularly as they relate to law enforcement officers.

- Ensure resources are readily available to all employees through a centralized database maintained at the state level. Utilize the U.S. Department of Veterans Affairs PTSD website and South Carolina program as models.

- Explore the possibility of mandating a certain number of hours of mental wellness/suicide prevention for law enforcement officers through POST.

- Encourage programs that live past the adjournment of the PTSD Task Force and continue the discussion with law enforcement and other executives that focus on prevention, identification and treatment options. Utilize current groups like the County Sheriffs of Colorado and the Colorado Chiefs of Police to further discussions on "best practices" like shared resources, peer support groups and Mayflower teams.

The legislative subcommittee meeting was adjourned at approximately 4:10 p.m.

Appendix H

Survey for Colorado Peace Officers

This survey was created by a Colorado Legislative Task Force concerning post-traumatic stress disorder (PTSD) within Colorado's peace officer population.

During September of this year, the Task Force is researching work-related peace officer PTSD and other relevant topics. We are charged with reporting our findings and making recommendations that include the best policies and practices for public employers of peace officers in Colorado (concerning identification, prevention, treatment, covered workers' compensation claims, standardized pre-employment psychological screenings, and education of both management and employees on this mental health illness).

Please carefully respond to each question. This survey is designed to provide anonymity for you and your agency, and you are not mandated to report your findings to anyone.

Within the first part of this survey, "Mental Health Resources" describes professionals and programs that provide "Mental Health Services," that is assistance with depression, anger, anxiety, addiction, stress, etc.

1. The number of sworn officers employed at my agency is approximately
   A. 1 to 49
   B. 50 to 99
   C. 100 to 299
   D. Over 300
2. My agency is located in an area of Colorado that can best be described as
   A. Rural
   B. Suburban
   C. Urban
3. My primary duties, in my current assignment, are best described as
   A. In the Field (law enforcement, parole officer, etc)
   B. In a facility (County Detention / Corrections)
4. I have attended Stress Management, Wellness, and or Resiliency Training
   A. In the past year
   B. At least once during the past five years
   C. At least once, but over five years ago
   D. Never
5. How familiar are you with Mental Health Resources available to you when experiencing problems in your personal and or professional life?
   A. Familiar with how to contact a mental health professional directly, without assistance
   B. Familiar with a co-worker or policy that can direct me to a mental health professional
   C. Unfamiliar with any process to access assistance from a mental health professional
6. How familiar are you with mental health resources provided by your health care provider (health insurance)?

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A. Familiar with professionals, for individual and or group therapy, compatible with my health care coverage, and the co-pay associated with each visit
B. Unfamiliar with specific mental health providers covered by my health care plan, but aware of a telephone number or website to acquire information for an appointment
C. Unfamiliar with any process to access mental health care with my health care plan

7. Not including your health care plan (health insurance), what mental health services are provided - free to you - by your agency?
   A. Police Psychologist employed by your agency
   B. Contract between your agency and a Police Psychologist(s)
   C. (EAP) Employee Assistance Program Only
   D. Unsure of mental health services provided to me (free of charge) by my agency or employer
8. During your employment, with your current agency, have you received mental health services through your health care plan (health insurance)?
   A. Yes
   B. No
9. During your employment, with your current agency, have you received mental health services through your agency's police psychologist or EAP?
   A. Yes
   B. No
10. If "Yes" to Question 9, did existing policy require approval, from someone within your agency, to obtain free mental health services from the police psychologist or EAP?
    A. Yes
    B. No
    C. Unsure
11. What is the best answer to describe the role of your agency's police psychologist or EAP
    A. Fitness For Duty evaluations are done by someone other than our police psychologist / EAP
    B. Our police psychologist / EAP provides both Fitness For Duty and mental health services within my agency
    C. Unsure
12. Does your agency have a Peer Support Program?
    A. Yes
    B. No
    C. Unsure
13. How familiar are you with the term and symptoms of Post Traumatic Stress Disorder (PTSD)?
    A. Familiar with the term, symptoms, diagnosis, and treatment of PTSD
    B. Familiar with the term and symptoms of PTSD only
    C. Familiar with the term PTSD only
    D. Unfamiliar with the term PTSD
14. How familiar are you with the term Post Traumatic Growth (PTG)?
    A. I am familiar with the definition and goals of PTG
    B. I have heard of PTG, but do not know what involves
    C. I have never heard of PTG

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15. Have you been diagnosed, by a professional, with PTSD?
    A. Yes
    B. No
16. If "Yes" to Question 15, is your diagnosis of PTSD a result of your employment as a law enforcement or corrections officer?
    A. Yes
    B. No
17. If "Yes" to Question 16, is your agency / employer aware of your work related PTSD diagnosis?
    A. Yes
    B. No
18. If "Yes" to Question 17, did you file a Workers' Comp claim for your work related PTSD diagnosis?
    A. Yes
    B. No
19. If "Yes" to Question 18, was your Workers' Comp claim for work related PTSD approved?
    A. Yes
    B. No
20. If "Yes" to Question 18, how would you describe the role played by Risk Management / Workers' Comp:
    A. An Ally
    B. An Adversary
    C. Neither an Ally nor Adversary
21. This concludes the first part of the survey. Please feel free to make brief comments, in this dialogue box, concerning your agency's mental health resources & services, and or your agency's Risk Management / Workers' Compensation.
    (dialogue box)

The second part of this survey is designed to allow an anonymous self-screening of areas related to traumatic stress. This survey is not a comprehensive assessment tool. It is a screening tool only. The accuracy of the survey is increased by an honest assessment of yourself. Some of the factors contributing to inaccurate reporting include denial, self-deception, or resistance to admitting that there may be problems. If you identify areas of concern, you may consider seeking resources offered through your agency, health care plan (health insurance), or health care provider (primary care physician).

The following questions are meant to assist you in finding areas of possible concern that may be hindering your quality of life in some way. Please carefully respond to each question. Please remember this survey is designed to provide anonymity for you and your agency, and you are not mandated to report your findings to anyone.

22. I have experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of myself or others.
    A. Yes
    B. No

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23. I responded to a traumatic event where I experienced intense fear, helplessness, or horror.
    A. Yes
    B. No
24. I experience recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
    A. Yes
    B. No
25. I have experienced reoccurring dreams of the event that are concerning to me.
    A. Yes
    B. No
26. I have experienced illusions, hallucinations, or a feeling as if I am “reliving the event” (including during periods of intoxication).
    A. Yes
    B. No
27. I experience physical reactivity or psychological distress when exposed to something that may resemble the event(s).
    A. Yes
    B. No
28. I have made an effort to avoid thoughts, feelings, or conversations associated with the specific event(s).
    A. Yes
    B. No
29. I find myself avoiding activities, places, or people that rouse recollections of the trauma.
    A. Yes
    B. No
30. I have experienced an inability to recall important aspect(s) of the event(s).
    A. Yes
    B. No
31. I have noticed diminished interest or participation in significant activities or feelings of detachment or estrangement from others since the event(s).
    A. Yes
    B. No
32. I have experienced a difficulty to express an emotion that was present before the event(s).
    A. Yes
    B. No
33. I have experienced a sense of a shortened future after experiencing the event (for instance, I do not expect to have a career, marriage, children, or a normal life span).
    A. Yes
    B. No
34. Since the event(s), I have experienced difficulty falling or staying asleep.
    A. Yes
    B. No

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35. Since the event(s), I have experienced irritability or outbursts of anger.
    A. Yes
    B. No
36. Since the event(s), I have experienced difficulty concentrating.
    A. Yes
    B. No
37. Since the event(s), I have experienced hyper-vigilance (constantly tense and on guard).
    A. Yes
    B. No
38. Since the event(s), I have experienced an exaggerated startle response.
    A. Yes
    B. No
39. Answering “Yes” to two or more, of Questions 21 through 37, may indicate a possible area of concern and you should consider seeking further assistance from a mental health professional. This concludes the survey. Please feel free to make any brief comments, in this dialogue box, concerning Post Traumatic Stress and PTSD within Colorado law enforcement and corrections. (dialogue box)

Appendix I

Survey for Police Chiefs, Sheriffs, Colorado State Patrol, & Colorado Department of Corrections

This survey was created by a Colorado Legislative Task Force concerning post-traumatic stress disorder (PTSD) within Colorado's peace officer population.

During September of this year, the Task Force is researching work-related peace officer PTSD and other relevant topics. We are charged with reporting our findings and making recommendations that include the best policies and practices for public employers of peace officers in Colorado concerning identification, prevention, treatment, covered workers' compensation claims, standardized pre-employment psychological screenings, and education of both management and employees on this mental health illness.

Please carefully respond to each question. This survey is designed to provide anonymity to you and your agency.

1. The number of peace officers employed at my agency:
   A. 1 to 49
   B. 50 to 99
   C. 100 to 299
   D. Over 300
2. My agency is located in an area of Colorado that can best be described as:
   A. Rural
   B. Suburban
   C. Urban
3. My agency can best be described as
   A. Law Enforcement
   B. Corrections
4. Which scenario best describes the Psych Services offered to the peace officers you employ:
   A. My agency employs a "Police Psychologist"
   B. My agency has a contract with a "Police Psychologist(s)"
   C. My agency does not employ or contract with a "Police Psychologist" but utilizes the services provided by a local or state Employee Assistance Program (EAP)
   D. My agency currently does not have a "Police Psychologist" or EAP for our peace officers
5. If you have Psych Services / EAP for your officers, how many sessions are they allowed? If sessions are limited, is it per incident or per calendar year?
   (dialogue box)
6. If you have Psych Services / EAP for your officers, do they need approval from a commander or your administration before utilizing services?
   A. Yes

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B. No

7. What assignments (i.e. undercover, homicide, accident reconstruction, child abuse, etc) do you require your officers to seek out Psych Services prior to, during, and or after appointment to that position?
   (dialogue box)
8. Are your officers encouraged to have an annual, mental health check-up (evaluation)?
   A. Yes
   B. No
   C. Unsure
9. If "Yes" to Question 8, the annual, mental health check-up (evaluation) is considered:
   A. Completely private and confidential between the mental health professional and officer
   B. Part of a Fitness For Duty where the results are reported to your administration
10. Which example best describes the Psych Services / EAP for your officers:
    A. The mental health professional provides both Psych Services to our officers and Fitness For Duty Evaluations for my agency
    B. The mental health professional providing Psych Services to our officers is NEVER used for a Fitness For Duty evaluation
11. What duty related events do you consider as potentially causing a traumatic stress reaction?
    (dialogue box)
12. What symptoms, displayed by an officer, would cause you to make a referral to Psych Services?
    (dialogue box)
13. Does your agency provide training related to stress, trauma, and resiliency to Recruits during their Academy and or FTO Training?
    A. Yes
    B. No
14. Does your agency provide Continuing Education / In Service training to all officers related to stress, trauma, and resiliency?
    A. Yes
    B. No
15. If "Yes" to Question 14, is this Continuing Education / In Service provided annually?
    A. Yes
    B. No
16. Does your agency have an active Peer Support Team (within the definition of C.R.S. 13-90-107 where the members have been officially designated by you and trained in peer support skills)?
    A. Yes
    B. No

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17. During the past 15 years (from 2000 to today), how many Workers' Comp claims, for PTSD, have been made by your officers?
    (dialogue box)
18. How many of these claims, during the past 15 years, were successful?
    (dialogue box)
19. During the interim, from the time the claim was made, to the final decision by Risk Management / Workers' Comp, did your officers have funding available for ongoing treatment (i.e. from a foundation, employee organization, etc)?
    A. Yes
    B. No
    C. Unsure
20. Should there be a policy, similar to when an officer is exposed to bodily fluids (for Hepatitis, HIV, etc), to report exposure to a traumatic event?
    A. Yes
    B. No
    C. Unsure
21. What do you consider the biggest obstacle in providing Psych Services for your officers:
    A. Lack of qualified mental health professionals within your area of the state
    B. Lack of funding to contract with qualified mental health professionals
    C. Both "A" and "B"
    D. Other
       (dialogue box)
22. Please provide us with further comments or concerns regarding PTSD among Colorado peace officers (i.e. prevention, identification, treatment, etc)
    (dialogue box)

Psychological Fitness-for-Duty Evaluation Guidelines

Ratified by the IACP Police Psychological Services Section
Philadelphia, Pennsylvania, 2013

1. Purpose

1.1 The IACP Police Psychological Services Section (PPSS) developed these guidelines to educate and inform the public safety agencies that request fitness-for-duty evaluations (FFDEs) and the practice of examiners who perform them.

1.2 These guidelines are most effectively used through collaboration between examiners and public safety agencies. It is desirable that these guidelines be reviewed by both the referring agency and the examiner and that any conflicts between an agency's or examiner's policies or practices and these guidelines be discussed and the rationale for action contrary to the guidelines be documented before commencing the FFDE.

2. Limitations

2.1 The term "guidelines" refers to statements that suggest or recommend specific professional behavior, endeavors, or conduct for examiners. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and facilitate a high level of practice by examiners. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional situation. They are not definitive, and they are not intended to take precedence over the judgment of examiners.

2.2 These guidelines are not intended to serve as a basis for disciplinary action or civil or criminal liability. The standard of care is established by a competent authority not by the guidelines. No ethical, licensure, or other administrative action or remedy, nor any other cause of action, should be taken *solely* on the basis of an examiner practicing in a manner consistent or inconsistent with these guidelines.

2.3 These guidelines are not intended to establish a rigid standard of practice for FFDEs. Instead, they are intended to reflect the commonly accepted practices of the PPSS members and the agencies they serve.

2.4 Each of the guidelines may not apply in a specific case or in all situations. The decision as to what is or is not done in a particular instance is ultimately the responsibility of the agency and examiner.

2.5 These guidelines are written to apply to agencies within the jurisdiction of the United States and, as such, may require modification for use by agencies in other countries.

3. **Definition**

3.1 A psychological FFDE is 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. The central purpose of an FFDE is to determine whether the employee is able to safely and effectively perform his or her essential job functions.

4. **Threshold Considerations**

4.1 Referring an employee for an FFDE is indicated whenever there is an objective and reasonable basis for believing that the employee may be unable to safely and/or effectively perform his or her duties due to a psychological condition or impairment. An objective basis is one that is not merely speculative but derives from direct observation, credible third-party report, or other reliable evidence.

4.2 When deciding whether or not to conduct an FFDE, both the agency and examiner should take into account its potential usefulness and appropriateness given the specific circumstances, and the agency should consider whether other remedies (e.g., education, training, discipline, physical FFDE) might be more appropriate or useful instead of, or in addition to, a psychological FFDE.

4.3 In all consultations, the examiner strives to remain impartial and objective and to avoid undue influences by any of the parties involved in the case.

4.4 In general, mental health professionals refrain from rendering fitness-for-duty opinions when they are not conducting an FFDE, such as when providing debriefings in the context of an officer-involved shooting or similar services in other situations when return to duty is at issue.

5. **Examiner Qualifications**

5.1 In light of the nature of these evaluations and the potential consequences to the agency, the examinee, and the public, it is important for examiners to perform FFDEs with maximum attention to the relevant legal, ethical, and practice standards. Such standards include, but are not limited to, the American Psychological Association's (APA's) Ethical Principles of Psychologists and Code of Conduct. Examiners should also consider and be guided by statutory and case law applicable to the employing agency's jurisdiction. Consequently, it is recommended that these evaluations be conducted only by a qualified mental health professional. At a minimum, it is recommended that examiners:

5.1.1 be licensed psychologists or psychiatrists with education, training, and experience in the diagnostic evaluation of mental and emotional disorders;

5.1.2 be competent in the evaluation of law enforcement personnel;

5.1.3 be familiar with the essential job functions of the employee being evaluated and the literature pertinent to FFDEs, especially that which is related to police psychology;

5.1.4 be familiar with, and act in accordance 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);

5.1.5 be familiar with, and be guided by, other applicable professional guidelines, including, but not limited to, the Specialty Guidelines for Forensic Psychology;

5.1.6 satisfy any other minimum requirements imposed by local jurisdiction or law;

5.1.7 recognize and make ongoing efforts to maintain and develop their areas of competence based on their education, training, supervised experience, consultation, study, and professional experience; and

5.1.8 seek appropriate consultation, supervision, and/or specialized knowledge to address pertinent issues outside their areas of competence that may arise during the course of an FFDE.

5.2 When an FFDE is known 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.

6. Multiple Relationships and Conflicts of Interest

6.1 Examiners should decline to accept an FFDE referral when personal, professional, legal, financial, or other competing interests or relationships could reasonably be expected to:

6.1.1 impair their objectivity, competence, or effectiveness in performing their functions; or

6.1.2 expose the person or agency with whom the professional relationship exists to harm or exploitation (e.g., conducting an FFDE on an employee who had previously been in counseling or therapy with the examiner, evaluating an individual with whom there has been a business or significant social relationship); or

6.1.3 pose potential conflicts of interest related to recommendations or the provision of services following the evaluation (e.g., referring an examinee to oneself for subsequent treatment).

6.2 If such conflicts are unavoidable or deemed to be of minimal impact, the examiner should disclose the potential conflicts to all affected parties and obtain their informed consent to proceed with the evaluation. It is advisable that the disclosure by the examiner and consent by all parties be appropriately documented.

7. Referral Process

7.1 It is desirable that employers have FFDE policies and procedures that define such matters as circumstances that would give rise to an FFDE referral, mechanisms of referral and examiner selection, any applicable report restrictions, sharing results with the examinee, and other related matters.

7.2 It is advisable for the agency and examiner to consult before an FFDE commences in order to ensure that an FFDE is indicated in a particular case and that it is consistent with the examiner's training, experience, and capacity for objectivity.

7.3 It is recommended that the employer's referral to the examiner include a description of the objective evidence giving rise to concerns about the employee's fitness for duty and any particular questions that the employer wishes the examiner to address. In most circumstances, the referral, and the basis for it, should be documented in writing, either by the agency or the examiner.

7.4 In the course of conducting the FFDE, it is usually necessary for the examiner to receive background and collateral information regarding the employee's past and recent performance, conduct, and functioning. The information may include, but is not limited to, job class specifications and/or job description, 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. In some cases, an examiner may ask the examinee to provide relevant medical or mental health treatment records and other data for the examiner to consider. It is important that all collected information be clearly related to job performance issues and/or the suspected job-impairing mental condition. Where possible and relevant, it may prove helpful to gather collateral information and data from other collateral sources.

7.5 When some portion of the information requested by an examiner is unavailable or is withheld, the examiner must judge the extent to which the absence of such information may limit the reliability or validity of his or her findings and conclusions before deciding to proceed. If the examiner proceeds with the examination, it is recommended that the subsequent report include a discussion of any such limitations judged to exist.

8. Informed Consent and Authorization to Release of Information

8.1. An FFDE requires the informed consent of the examinee and the employer to participate in the examination. At a minimum, informed consent should include the following:

8.1.1. a description of the nature and scope of the evaluation;

8.1.2. the limits of confidentiality, including any information that may be disclosed to the employer without the examinee's authorization;

8.1.3. the party or parties who will receive the FFDE report of findings, and whether the examinee will receive a report or explanation of findings;

8.1.4. the potential outcomes and probable uses of the examination, including treatment recommendations, if applicable; and

8.1.5. other provisions consistent with legal and ethical standards for mental health evaluation conducted at the request of third parties

8.2 As part of the informed consent process, the examiner identifies the client(s) and communicates this to the examinee at the outset of the evaluation. Nevertheless, the examiner owes an ethical duty to both the referring agency and the examinee to be fair, impartial, competent, 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.

8.3 In addition to obtaining informed consent, it is recommended that the examiner obtain written authorization from the employee to release the examiner's findings and opinions to the employer. If such authorization is denied, or if it is withdrawn once the examination commences, the examiner should be aware of any legal restrictions in the information that may be disclosed to the employer without valid authorization.

9. **Evaluation Process**

9.1 Depending on the referral question and the examiner's clinical judgment, an FFDE examiner strives to utilize multiple methods and data sources in order to optimize the accuracy of findings. Examiners integrate the various data sources, assigning them relative weight according to their known reliability and validity. The range of methods and data sources used by an FFDE examiner frequently include:

9.1.1. a review of the relevant background and collateral information described in Guideline 7.4;

9.1.2. relevant psychological testing using assessment instruments and norms (e.g., personality, psychopathology, cognitive, specialized) appropriate to the referral question(s) and with validity and reliability that have been established for the current use. When such validity and reliability have not been established, the examiner should make known the strengths and weaknesses of that test or method;

9.1.3. a comprehensive clinical interview and mental status examination;

9.1.4. collateral interviews with relevant third parties if deemed necessary by the examiner; and

9.1.5. referral to, and/or consultation with, a specialist if deemed necessary by the examiner.

9.2 Prior to conducting collateral interviews of third parties, care should be taken to obtain informed consent from the employer, the examinee, or from the third party, as appropriate. This should include, at a minimum, an explanation of the purpose of the interview, how the information will be used, and any limits to confidentiality.

10. Report and Recommendations

10.1 Customarily, the examiner will provide a written report to the client agency that contains a description of the rationale for the FFDE, the methods employed, and whenever possible, a clearly articulated opinion that the examinee is presently fit or unfit for unrestricted duty.

10.1.1. The content of the report should be guided by the referral question(s), the employing agency's written policies and procedures, the applicable terms of any labor agreement, relevant law, the terms of informed consent, the employee's authorization.

10.1.2. Because FFDEs may become part of an adjudicative process, examiners strive to maintain detailed records that allow scrutiny of their work by others.

10.1.3. Findings and report should be presented in ways that promote understanding. Examiners strive to present their conclusions in a fair, nonpartisan, and thorough manner.

10.1.4. FFDE examiners consider and seek to make known that evaluation results can be affected by factors unique to, or differentially present in, FFDE contexts including response style, voluntariness of participations, and situational stress associated with involvement in labor and/or legal matters.

10.2 When an examinee is found unfit for unrestricted duty, it is advisable that the report contains, at a minimum, a description of the employee's functional impairments or job relevant limitations unless prohibited by law, agency policy, labor agreement, terms of the employee's disclosure authorization, or other considerations.

10.3 It is recognized that some examiners may be asked to provide opinions regarding necessary work restrictions, accommodations, interventions, or causation. Whether or not a recommended restriction or accommodation is reasonable for the specific case and agency is a determination to be made by the employer, not the examiner.

10.4 The examiner's findings and opinions are based on data available at the time of the examination. If additional relevant information is obtained after completion of the FFDE or it is determined that the original evaluation was based on inaccurate information, the employer may request that the examiner reconsider his or her conclusions in light of the additional information. Reconsideration or reevaluation also may be indicated in

circumstances in which an employee, previously deemed unfit for duty, subsequently provides information suggesting his or her fitness has been restored.

10.5 Some agencies may find differences of opinion between or among the examiner and other health care professionals. In such cases, it is advisable that the employer consider:

10.5.1. any differences in the professionals' areas of expertise and knowledge of the employee's job and work environment;

10.5.2. the objective basis for each opinion; and

10.5.3. whether the opinion is contradicted by information known to or observed by the employer.

10.6. Agencies are encouraged to handle FFDE reports in conformance with legal standards governing an employer's treatment of employee medical records.

11. Technological Considerations

11.1 For examiners who make use of electronic technology during the FFDE process, the examiner takes steps to ensure that relevant authorizations and safeguards are in place, which at a minimum should include the following:

11.1.1 informed consent is obtained from the examinee prior to audio taping or video recording the examination process, or before initiating any form of telepsychology service from a remote location;

11.1.2 utilization of video conference technology or telepsychology for conducting interviews or evaluations is confidential and secure, and the use of such technology is used in accordance with state law and/or practice standards established by local licensing boards; and,

11.1.3 all electronic reports and materials are sufficiently encrypted and password-protected to ensure confidentiality of transmitted or stored material, and are in accordance with the ethical guidelines associated with the state(s) in which the evaluation is being conducted.

12. Third-Party Observers and/or Recording Devices

12.1 Examiners consider the ethical, clinical, scientific, and legal issues when contemplating the presence of third-party observers and/or recording devices in an FFDE.

Endnotes

2.1 American Psychological Association. (2002). Criteria for practice guideline development and evaluation. *American Psychologist, 57,* 1048–1051. (p. 149, Section 1.2 Guidelines Versus Standards).

3.1. The ADA (Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 *et seq*.) requires that, when making a disability-related inquiry or conducting a medical examination of an *incumbent employee*, the employer must meet a fact-specific, individualized threshold; namely, that the questions or examination be "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, emphasis added).

A psychological evaluation constitutes a "disability-related inquiry" when it contains one or more questions likely to elicit information about a disability; see EEOC, 1995, p. 3) or constitutes a "medical examination" when it incorporates a procedure or test that seeks information about an individual's physical or mental impairments or health; see EEOC, 1995, p. 11).

Yin v. California (9th Cir. 1996), where the court held that the purpose of a fitness-for-duty evaluation "is not to determine the degree of disability the employee has suffered, but rather as to whether *illness or injuries* sustained restrict the employee from performing the full range of his/her normal work assignment" (at Footnote 17, emphasis added).

EEOC (1995). *ADA Enforcement Guidance: Preemployment Disability-Related Questions and Medical Examinations*, Compliance Manual, Volume II, Section 902, No. 915.002. Washington, DC: Equal Employment Opportunity Commission.

EEOC (2000). *Enforcement Guidance on Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act*, Compliance Manual, Volume II, Section 902, No. 915.002. Washington, DC: Equal Employment Opportunity Commission.

4.1 Objective evidence is reliable information, either directly observed or provided by a credible third party, that an employee may have or has a medical condition that will interfere with his ability to perform essential job functions or will result in direct threat. Where the employer forms such a belief, its disability-related inquiries and medical examinations are job-related and consistent with business necessity. EEOC (2000). *Enforcement Guidance on Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act*, Compliance Manual, Volume II, Section 902, No. 915.002. Washington, DC: Equal Employment Opportunity Commission.

4.3 *Sullivan v. River Valley S.D., 9 AD 1711* (6th Cir. 1999), "Though we need not decide today whether advice from an outside health professional is always necessary, we note that the district's obtaining advice that further examination was needed to determine Sullivan's fitness to work

buttresses the district's claim that it had reason to believe Sullivan could not perform some essential aspects of his job. This court has upheld requiring mental and physical exams as a precondition to returning to work. See *Pesterfield v. TVA*, 941 F.2d 437-38 (6th Cir. 1991)."

5.1 *People v. Hawthorne,* 203 Mich. 15, 291 N.W. 205 (1940). "This case established that professionals should be qualified as experts based on their knowledge of the specialized materials matters relevant to a case, not on the basis of their degree" (Heilbrun, Grisso & Goldstein, 2009). This case overruled an earlier lower court's decision to disallow a psychologist's testimony.

Jenkins v. United States, 307 F.2d 637 (D.C. Cir. 1962). "In Jenkins, the court ruled that psychologists, despite their lack of medical degree, could offer opinions as expert witnesses concerning the nature and existence of mental disorders, as long as they could demonstrate that they had training, knowledge, and experience about those matters" (Heilbrun, K., Grisso, T., & Goldstein, A. (2009). *Foundations of forensic mental health assessment*. New York: Oxford University Press.

American Psychological Association (2002). Ethical Principles of Psychologists and Code of Conduct. *American Psychologist, 57*, 1060-1073.5.1.5.

American Psychological Association (2013). Specialty Guidelines for Forensic Psychology. *American Psychologist*, *68*, 7-19.

FFD evaluations should be conducted by licensed psychologists with specialized knowledge, training and skill (Corey & Borum, 2013).

Corey, D.M. & Borum R. (2013). Forensic Assessment of High-Risk Occupations. In Otto R. K., & Weiner, I.B. Handbook of Psychology, Second Edition, Volume 11, Forensic Psychology. New Jersey: Wiley

5.1.7. Maintenance of competence is a professional standard and particularly important given the accelerating profusions of specialty knowledge and the corollary diminishing durability of such knowledge and related proficiencies.

American Psychological Association (2002). Ethical Principles of Psychologists and Code of Conduct. *American Psychologist, 57*, 1060-1073.

Neimeyer, G. J., Taylor, J. M., & Rozensky, R. H. (2012). The Diminishing Durability of Knowledge in Professional Psychology: A Delphi Poll of Specialties and Proficiencies. Professional Psychology: Research and Practice, 43, 364-371.

5.2 *Federal Rules of Evidence*, Rule 702 ("Testimony by Expert Witnesses"); *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993); *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923)

6.1 *Denhof et al. v. City of Grand Rapids*, 494 F.3d 534 (6th Cir. 2007), where the court held that the department-retained evaluating psychologist was not impartial and intended to find the plaintiffs

unfit regardless of what the actual fitness-for-duty evaluation results revealed. The court found that the psychologist had formed an adverse opinion about the plaintiffs before he examined them, that the police chief knew of this opinion, and, therefore, that the police chief could not assert a "safe harbor" defense based on an honest reliance on the psychologist's opinion.

Role conflict is to be attended to and managed in psycho-legal evaluations (Greenburg & Shuman, 1997).

Greenburg, S. A., & Shuman, D. W. (1997). Irreconcilable Conflict Between Therapeutic and Forensic Roles.

American Psychological Association (2002). Ethical Principles of Psychologists and Code of Conduct. *American Psychologist, 57*, 1060-1073.

American Psychological Association (2013). Specialty Guidelines for Forensic Psychology. *American Psychologist*, *68*, 7-19.

7.3 Examiners should establish at the outset the specific referral question(s). See Corey & Borum, 2013; APA EPPCC, 2002; SGFP, 2013.

Corey, D.M. & Borum R. (2013). Forensic Assessment of High-Risk Occupations. In Otto R. K., & Weiner, I.B. Handbook of Psychology, Second Edition, Volume 11, Forensic Psychology. New Jersey: Wiley

American Psychological Association (2002). Ethical Principles of Psychologists and Code of Conduct. *American Psychologist*, 57, 1060-1073.

American Psychological Association (2013). Specialty Guidelines for Forensic Psychology. *American Psychologist*, 68, 7-19.

7.4 *Colon v. City of Newark*, #A-3260-03T23260-03T2, 2006 WL 1194230 (N.J.A.D. 2006); *Thomas v. Corwin*, 483 F.3d 516 (8th Cir. 2007); *Thompson v. City of Arlington*, 838 F.Supp. 1137.

"An 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. 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" (EEOC. (2000). *Enforcement Guidance on Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act: Compliance Manual* (Vol. II, Sect. 902, No. 915.002. Washington, DC: Equal Employment Opportunity Commission).

It is principle to the conduct of psycho-legal evaluations that the examiner rely on multiple modes and methods of data collection (Heilbrun, Grisso, & Goldstein, 2009).

Heilbrun, K., Grisso, T., & Goldstein, A. M. (2009). Foundations of forensic mental health assessment. New York: Oxford University Press.

It is a standard of practice in psycholegal evaluations to include in a report of assessment findings any limitations to the reliability and validity of the assessment.

American Psychological Association (2013). Specialty Guidelines for Forensic Psychology. *American Psychologist*, *68*, 7-19.

7.5 *General Electric Co. v. Joiner*, 522 U.S. 136 (1997). Held that a district court judge may exclude expert testimony when there are gaps between the evidence relied on by an expert and his conclusion, and that an abuse-of-discretion standard of review is the proper standard for appellate courts to use in reviewing a trial court's decision of whether expert testimony should be admitted.

8.1 *Schloendorff v. Society of New York Hospital*, 211 NY 125, 105 N.E. 92 (N.Y. 1914). Landmark case establishing the legal principle of informed consent or, in the alternative, disclosure, as a basic element in the relationship between a health care provider and a patient or examinee.

Berthiaume v. Caron, Bivins & Donohue, (1st Circuit, 1998), 142 F.3d 12, includes a discussion of what constitutes duress in consenting to testing. Plaintiff objected to the nature of testing, but the written consent he gave and his cooperation with testing was more persuasive to the court than his after the fact objections.

Colon v. City of Newark, #A-3260-03T23260-03T2, 2006 WL 1194230 (N.J.A.D. 2006) is relevant to informed consent of the employer: employer failed to provide relevant data to the evaluating psychologist and Appellate court sustained a negligent retention verdict.

8.1.1. *Perez v. City of Austin, et al*. #A-07-CA-044 AWA, 2008 WL 1990670 (W.D. TEX.) Officer Perez prevailed in admitting into evidence his self obtained 2nd opinion FFDE in support of his claim that the Austin Police Department's psychologist failed to disclose the true nature of the evaluation, i.e., failed to provide full informed consent.

8.1.2. *Thompson v. City of Arlington,* 838 F.Supp. 1137; 1993 U.S. Dist. N. D. Texas. Police officer can be compelled to release medical records, overriding constitutional right to privacy in interest of public safety.

Redmond v. City of Overland Park, 672 F.Supp.473 D. Kansas 1987.

Summary judgment: ER prevailed as a matter of law in its right to carry out an FFDE vs the employee's right to privacy.

McKenna v. Fargo, 1978 U.S. Dist. 451 F.Supp. 1381 (D.N.J 1978), the court, in weighing the individual right to privacy with the state's interest in disclosure of private information by a public employee, considered important "the nature of the work to be done by the employee and the dangers that can result from it."

8.1.3 *Bass v. City of Albany*, 968 F.2d 1067 (11th Cir. 1992), if terminated as a result of an FFDE, the examinee has the right to understand the basis for the termination, which would therefore include access to the psychological report and all data relevant to the production of that report.

8.1.4 *Thomas v. Corwin*, 483 F.3d 516 (8th Cir. 2007), a potential outcome of non-compliance with the FFDE process includes termination.

8.2 It is important for the examiner to clarify the ethical responsibilities to each party to the case. Fisher, M. A. (2009).

Replacing "Who Is the Client?" With a Different Ethical Question. Professional Psychology: Research and Practice, 40, 1-7.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. (2000b). Title 45, Subtitle A, Subchapter C, Part 164, Subpart E, Privacy of Individually Identifiable Health Information.

8.3 *Pettus v. Cole* (1996, Cal. App.) California Appeals court case which found that the employer does not have a right to personal information or private health information, only job relevant information, and an explicit release of information is required for the evaluator to release information to the employer beyond job relevant functional capacity information.

9.1 It is axiomatic in the practice of psychological assessment that the examiner rely on multiple methods and data sources to reduce bias and error, and to increase accuracy. See Packer & Grisso (2011)

Packer, I. K. and Grisso, T. (2011). Special Competencies in Forensic Psychology. New York: Oxford University Press. 9.4

American Psychological Association (2013). Specialty Guidelines for Forensic Psychology. *American Psychologist*, *68*, 7-19.

Anderson v. Little League Baseball, Inc., 794 F.Supp. 342, 61 USLW 2050 (D. Ariz. 1992).

10. Corey (2011) provides a detailed treatment regarding the standards of practice related to FFDE reporting and recommendations. Also see Anfang, Faulkner, Fromson & Gendel (2005) and Gold & Shuman (2009).

Corey, D. M. (2011). Principles of fitness-for-duty evaluations for police psychologists. In J. Kitaeff (Ed.), Handbook of police psychology (pp. 263-293). New York, NY: Routledge.

Anfang, S. A., Faulkner, L. R., Fromson, J. A., & Gendel, M.H. (2005). American Psychiatric Association resource document on guidelines for psychiatric fitness-for-duty evaluations of physicians. Journal of the American Academy of Psychiatry and the Law, 33, 85-88.

Gold, L. H., & Shuman, D. W. (2009). *Evaluating mental health disability in the workplace*. New York: Springer Science & Business Media.

10.1 *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 Merit System Review Board concluded that FFD reports that were "entirely conclusory, devoid of any medical documentation or explanation in support of their conclusions" carried less "credibility and reliability" than those including "a thorough, detailed, and relevant medical opinion addressing the medical issues of the agency's removal action."

10.2 Heilbrun, Grisso, and Goldstein (2009) provide guidance on selecting models for communicating the examination results and state that the examiner articulates the connection between the psychological disorder and the functional [job] impairment/s.

Heilbrun, K., Grisso, T., & Goldstein, A. M. (2009). *Foundations of forensic mental health assessment*. New York: Oxford University Press.

EEOC Enforcement Guidance, 2000; *Lassiter v. Department of Justice* (1993).

10.3 "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" (*ADA Technical Assistance Manual*, January 1992. Publication EEOC-M-1A (10/29/2002 Addendum).

"Employers do not have a cognizable interest in dictating a course of medical treatment for employees who suffer nonindustrial injuries. That is a matter for the employees to decide in consultation with their own health care providers—medical professionals who have their patients' best interests at heart." *Pettus v. Cole*, 49 Cal.App.4th 402 (1996).

10.5 *Hammon v DHL Airways*, 997 (1999); *Larson v. Koch Refining Co*. (1996); *Barnett v. U.S. Air, Inc*. (2000).

"An employer should be cautious about relying solely on the opinion of its own health care professional that an employee poses a direct threat where that opinion is contradicted by documentation from the employee's own treating physician, who is knowledgeable about the employee's medical condition and job functions, and/or other objective evidence. In evaluating conflicting medical information, the employer may find it helpful to consider: (1) the area of expertise of each medical professional who has provided information; (2) the kind of information each person providing documentation has about the job's essential functions and the work environment in which they are performed; (3) whether a particular opinion is based on speculation or on current, objectively verifiable information about the risks associated with a

particular condition; and, (4) whether the medical opinion is contradicted by information known to or observed by the employer (e.g., information about the employee's actual experience in the job in question or in previous similar jobs)" (EEOC. (2000). *Enforcement Guidance on Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act: Compliance Manual* (Vol. II, Sect. 902, No. 915.002). Washington, DC: Equal Employment Opportunity Commission.)

10.6 Health Insurance Portability and Accountability Act (HIPAA), 2000.

12.1 See Otto & Krauss (2009) regarding the ethical, clinical, and legal issues related to deciding whether or not to permit third-party observers (e.g., the impact/affect of third-party's presence on the interview and objective testing)

Otto, R. K., & Krauss, D. A. (2009, August 10). Contemplating the presence of third party observers and facilitators in psychological evaluations. Assessment Online First. doi:10.1177 /1073191109336267

Peer Support Guidelines

Ratified by the IACP Police Psychological Services Section
Chicago, Illinois, 2011

1. Purpose

1.1 The goal of peer support is to provide all public safety employees in an agency the opportunity to receive emotional and tangible support through times of personal or professional crisis and to help anticipate and address potential difficulties. Ideally, peer support programs are developed and implemented under the organizational structure of the parent agency. For a peer support program to work effectively, it must have support from the highest levels within an organization.

1.2 These guidelines are intended to provide information and recommendations on forming and maintaining a peer support structure for sworn and civilian personnel in law enforcement agencies. The guidelines are not meant to be a rigid protocol but reflect the commonly accepted practices of the IACP Psychological Services Section members and the agencies they serve. The guidelines work best when applied appropriately to each individual and agency situation.

2. Definitions

2.1 A peer support person (PSP), sworn or civilian, is a specifically trained colleague, not a counselor or therapist. A peer support program can augment outreach programs such as employee assistance programs (EAPs), in-house treatment programs, and out-of-agency psychological services and resources, but not replace them. A peer support person is trained to provide both day-to-day emotional support for department employees as well as to participate in a department's comprehensive response to critical incidents. PSPs are trained to recognize and refer cases that require professional intervention or are beyond their scope of training to a licensed mental health professional.

2.2 To increase the level of comfort and openness in PSP contacts, there must be assurances that such information will be protected. There are three levels of non-disclosure of personal information to differentiate in this context:

2.2.1 Privacy is the expectation of an individual that disclosure of personal information is confined to or intended for the PSP only.

2.2.2 Confidentiality is a professional or ethical duty for the PSP to refrain from disclosing information from or about a recipient of peer support services, barring any exceptions that should be disclosed at the outset (See Section 6).

2.2.3 Privilege is the legal protection from being compelled to disclose communications in certain protected relationships, such as between attorney and client, doctor and patient, priest and confessor, or in some states, peer support persons and sworn or civilian personnel.

2.3 Some examples of applicable activities for a PSP include the following:

2.3.1 Hospital visitation

2.3.2 Career issues support

2.3.3 Post–critical incident support

2.3.4 Death notification

2.3.5 Substance abuse and EAP referrals

2.3.6 Relationship issues support

2.3.7 Support for families of injured or ill employees

2.3.8 On-scene support for personnel immediately following critical incidents

3. Administration

3.1 Departments should have a formal policy that grants peer support teams departmental confidentiality to encourage the use of such services. Such a departmental policy must be mindful of the jurisdiction's laws regarding legal privilege and confidentiality that apply to PSPs. PSPs shall not be asked to give, nor shall they release, identifying or confidential information about personnel they support. The only information that management should receive about peer support cases is anonymous statistical information regarding utilization of PSP services.

3.2 Departments are strongly encouraged to use a steering committee in the formation of the peer support program to provide organizational guidance and structure. Participation by relevant employee organizations and police administrators is encouraged during the initial planning stages to ensure maximum utilization of the program and to support assurances of confidentiality. Membership on the steering committee in subsequent stages should include a wide representation of involved sworn and civilian parties as well as a mental health professional licensed in the department's jurisdiction, preferably one who is knowledgeable about the culture of law enforcement.

3.3 It is beneficial for PSPs to be involved in supporting individuals involved in critical incidents, such as an officer-involved shooting or when an employee is injured or killed. PSPs often provide a valuable contribution by being available to make the appropriate referrals in response to officers and other employees dealing

with general life stressors or life crises. PSPs also make an invaluable addition to group interventions in conjunction with a licensed mental health professional.

3.4 In order for the department that has a PSP team to meet the emerging standard of care in peer support programs, the department should have clinical oversight and professional psychological consultation continuously with a licensed mental health professional who is qualified to provide that consultation to the PSP team. The role and scope of the professional mental health consultant will be mutually determined by the agency and the mental health professional.

3.5 A peer support program shall be governed by a written procedures manual that is available to all personnel.

3.6 Individuals being offered peer support may voluntarily accept or reject a PSP by using any criteria they choose.

3.7 Management may choose to provide non-compensatory support for the PSP program.

3.8 Departments are encouraged to train as many employees as possible in peer support skills. Peer support team size varies throughout agencies depending on the size and resources available to each agency. The number of PSPs depends on many variables: the crime level and geographical area covered by the agency; the number and size of divisions within a department; who is transferring, retiring, or promoting; and the agency budget.

3.8.1 Ideally, peer support teams will have enough trained and accessible members to provide services to all sworn and civilian department personnel, across all shifts and divisions. Team size needs to be manageable by program leaders or coordinators. Departments are encouraged to have sworn and civilian members of the agency available to increase the commonality when responding to personnel in different departmental positions (e.g., a sworn officer versus a telecommunications operator).

3.8.2 Larger departments are encouraged to disseminate PSPs across divisions, shifts, and sworn and civilian personnel throughout the agency. Conversely, smaller departments may need to combine resources with adjacent agencies, particularly for training and critical incident support. Many critical incident response teams already exist across services (police, fire, paramedics, dispatchers, and so on). Additionally, building interagency team relationships is beneficial for major incidents where the agency's PSPs themselves are close to the incident and may desire support (such as after an employee death or suicide).

3.8.3 Program managers are advised to consider long-term team planning in order to balance the impact of transfers, promotions, and retirements on the team size and availability.

3.9 A peer support program coordinator should be identified to address program logistics and development. This individual coordinates peer support activation, makes referrals to mental health professionals, collects utilization data, and coordinates training and meetings.

3.10 The peer support program is not an alternative to discipline. A PSP does not intervene in the disciplinary process. A PSP may provide support for the employee(s) under investigation or during a disciplinary process but should refrain from discussing the incident itself. Further, the employee(s) must be cautioned that any information shared with the PSP regarding the incident in question may not be confidential based on agency policies and jurisdictional requirements.

4. Selection/Deselection

4.1 PSPs should be volunteers who are currently in good standing with their departments and who have received recommendations from their superiors and/or peers. It may be helpful to include an interview process. The interview panel may consist of peer support members and the licensed mental health professional associated with the peer support team.

4.2 Considerations for selection of PSP candidates include, but are not limited to, previous education and training; resolved traumatic experiences; and desirable personal qualities such as maturity, judgment, personal and professional ethics, and credibility.

4.3 A procedure should be in place that establishes criteria for deselection from the program. Possible criteria include breach of confidentiality, failure to attend training, or loss of one's good standing with the department.

4.4 PSPs must be provided with the option to take a leave of absence and encouraged to exercise this option when personal issues or obligations require it.

5. Consultation Services from Mental Health Professionals

5.1 A peer support program must have mental health consultations and training. Preferably, this consultation should be available 24 hours a day and should be with a licensed mental health professional who is familiar with public safety and the specific nature of the agency involved.

5.2 PSPs need to be aware of their personal limitations and should seek advice and counsel in determining when to disqualify themselves from working with problems for which they have not been trained or problems about which they may have strong personal beliefs.

6. Confidentiality

6.1 Departments should have a policy that clarifies confidentiality guidelines and reporting requirements and avoids role conflicts and multiple relationships.

6.2 PSPs must respect the confidentiality of their contacts, must be fully familiar with the limits of confidentiality, and must communicate those limits to their contacts. The extent and limits of confidentiality needs to be explained to the individuals directly served at the outset and, ideally, will also be provided through agency-wide trainings.

6.3 Limits to confidentiality must be consistent with state and federal laws as well as departmental policy. Recipients of peer support should be advised that there is usually no confidentiality for threats to self, threats to others, and child and elder abuse. Additional exceptions to confidentiality may be defined by specific state laws or department policies. In general, the fewer confidentiality restrictions, the more confidence department members will have in the program. These should be well defined in the PSP manual, including procedures to follow when one of these exceptions to confidentiality occurs.

6.4 It is essential that PSPs advise members of the level of, and limits to, confidentiality and legal privilege that they can offer. PSPs must demonstrate knowledge of the limitations to these protections.

6.5 PSP members must have a well-informed, working knowledge of the three **overlapping** principles that have an impact on the boundaries surrounding their communications with members within the role of peer support. Those principles are *privilege*, *confidentiality*, and *privacy*.

6.6 PSPs must not provide information to supervisors or fellow peer support members obtained through peer support contact and should educate supervisors on the confidentiality guidelines established by the department.

6.7 A PSP must not keep written formal or private records of supportive contacts other than non-identifying statistical records that help document the general productivity of the program (such as number of contacts).

6.8 PSPs should sign a confidentiality agreement, indicating their agreement to maintain confidentiality as defined above. The agreement should also outline the consequences to the PSP for any violation of confidentiality.

7. Role Conflict

7.1 PSPs refrain from entering relationships if the relationship could reasonably be expected to impair objectivity, competence, or effectiveness in performing his or her role or otherwise risks exploitation or harm to the person with whom the relationship exists. For example, PSPs avoid religious, sexual, or financial entanglements with receivers of peer support. PSPs must receive training related to handling the complexities that can develop between PSPs and receivers of peer support.

7.2 Because of potential role conflicts involved in providing peer support, including those that could affect future decisions or recommendations concerning assignment, transfer, or promotion, PSPs should not develop peer support relationships between supervisors or subordinates.

7.3 A trained PSP knows when and how to refer peers, supervisors, or subordinates to another PSP member, chaplain, or mental health professional to avoid any potential conflicts of interest. This includes recognition that a large number of contacts between a PSP and any one individual may be an indication that a referral is needed.

7.4 Supervisors may have additional requirements regarding the reporting of issues such as sexual harassment, racial discrimination, and workplace injury that may place the supervisor or the agency in jeopardy if the procedures are not followed. PSPs cannot abdicate their job responsibility as officers or supervisors by participating in the program. Each agency must evaluate supervisor responsibilities and the viability of having supervisors as PSPs.

8. Training

8.1 The steering committee identifies appropriate ongoing training for PSPs.

8.2 PSPs should be required to advance their skills through continuing training as scheduled by the program coordinator. It is recommended that four hours of update training per quarter be provided to peer support members.

8.3 Relevant introductory and continuing training for PSP could cover the following topics:

8.3.1 Confidentiality

8.3.2 Role conflict

8.3.3 Limits and liability

8.3.4 Ethical issues

8.3.5 Communication facilitation and listening skills

8.3.6 Nonverbal communication

8.3.7 Problem assessment

8.3.8 Problem-solving skills

8.3.9 Cross-cultural issues

8.3.10 Psychological diagnoses

8.3.11 Medical conditions often confused with psychiatric disorders

8.3.12 Stress management

8.3.13 Burn-out

8.3.14 Grief management

8.3.15 Domestic violence

8.3.16 HIV and AIDS

8.3.17 Suicide assessment

8.3.18 Crisis management intervention

8.3.19 Work-related critical incident stress management

8.3.20 Alcohol and substance abuse

8.3.21 When to seek licensed mental health consultation and referral information

8.3.22 Relationship issues and concerns

8.3.23 Military support

8.3.24 Local Resources (e.g., social services, AA meetings, child care, and so on)

Appendix L

2013 Wellness Rewards Guidelines

The Need For a Continued Wellness Rewards Program

Many Americans are in poor health today. The reason, for some, is an inability to access adequate health care, a nutritious diet, or both. For others, a decision to not exercise, eat right, and visit a doctor. Some acquire disease or mental illness, but resources to regulate or eliminate the problem are unavailable. Still others choose to ignore disease or opt to self-medicate with tobacco, alcohol, and drug abuse. There are many reasons and circumstances for the poor overall health of U.S. citizens. Look at the ripple effects of just one example (obesity) and one solution (exercise).

During the past 20 years there has been a dramatic increase in obesity in the United States and rates remain high. In 2010, no State had a prevalence of obesity less than 20% (Colorado was at 20% - 24%, twenty-four States were at 25% - 29%, and twelve States were in excess of 30%). Obesity is related to hundreds of thousands of preventable deaths each year and billions of dollars in health care costs. Obesity significantly contributes to high blood pressure, elevated levels of blood cholesterol, type 2 diabetes, congestive heart failure, heart disease, stroke, liver disease, gallbladder disease, gallstones, gout, sleep apnea, osteoarthritis, cancer (endometrial, breast, prostrate, & colon), gynecological problems, and psychological disorders (depression, eating disorders, distorted body image, & low self-esteem).

Exercise reduces the risk of dying prematurely because exercise reduces the development of heart disease, diabetes, high blood pressure, colon cancer, depression, and anxiety. Simultaneously, exercise builds healthy bones, muscles, & joints while promoting psychological well-being.

In addition to acquiring and maintaining a healthy lifestyle, like regular exercise, preventative health care enables us to prevent or delay the onset of disease. Acquiring wellness – in mind, body, & spirit – requires good habits and prevention.

We Have Both Advantages and Challenges

As employees of the Denver Police Department, with stable employment and access to high quality preventative services, we have an advantage over many other Americans. This solid platform provides an opportunity to engage in exercise, eat healthy foods, and seek preventative health services. With these basic needs met, we are in a position to acquire information about our personal health and health care, leading us to healthy choices for lifelong wellness.

Currently Americans can expect to live 78 years (but with only 69 of these years spent in good health). In contrast, American police officers do not live as long. One study suggests the average age at death, for police officers, is 66 years. A recent study in Florida, comparing their general population to the law enforcement & corrections population, determined an officer's lifespan, on average, is reduced by 12 years. Other studies suggest many police officers die within five years of retirement.

Stress, Trauma, & Shift Work

So what is going on? Were we not hired specifically for our physical & mental fitness? Do we not continue to earn a decent wage, and have we not always been provided with health insurance? In the realms of mind, body, & spirit, compared to the general population, we should be thriving. The answers can be found in the degree and frequency of stress in police work, critical incidents exposing us to psychological trauma, and shift work.

Stress, alone, contributes to heart disease, weight gain, high blood cholesterol, diminished immune system, premature aging, and increased risk of cancer.

Unresolved psychological trauma adversely impacts our overall health and quality of life with flashbacks, disrupted sleep from dreams, emotional numbness, loss of enjoyment in day-to-day life, feelings of hopelessness, problems with memory and concentration, irritability, anger, relationship difficulties, and self-destructive behavior (i.e. alcohol abuse).

Shift work involves the hours we work (conflicting with the human circadian cycle) resulting in higher rates of illness. Shift work is exacerbated by overtime, court appearances, and child care responsibilities because these duties compete with sleep and inhibit regular exercise, proper diet, and family life.

A Self-Paced Solution

Because we have stable employment and access to health care, we can empower ourselves, as individuals, to seek preventative care, to embrace both physical and mental wellness. We must choose a path of healthy diet and lifestyle while avoiding tobacco and alcohol abuse.

The ***2013 Wellness Rewards Program*** offers time off incentives for engaging in healthy behaviors and activities that ultimately lead to improving your long term well being. Only qualifying activities performed between January 1, 2013 and December 31, 2013 will be eligible for time off incentives. Participating is as simple as engaging in healthy behavior, logging your activities with the ***POWER*** Program coordinator (Technician Danny Veith, Headquarters Room 502), and redeeming points for time off.

Using a point system, each healthy behavior has an assigned value. Participants accumulate points during the year, depending on the healthy behaviors and activities they engage in, and can earn in excess of 700 points (exchanging 250 points for one day off; 500 points for two days off).

There are many benefits to participating in this program. Over the long term, I hope you will develop new healthy habits that become part of your lifestyle and contribute to your overall well being.

Stay Safe, Be Well -

Technician Danny Veith – Police Officer Wellness & Employee Resources (***POWER***)

The Points

Points are tallied each quarter, and the total points accrued between January 1st and December 31st of each year can be applied towards a day off: 250+ total points is equivalent to one day off; 500+ total points is equivalent to two days off (maximum award of two days off each year). Points earned from January of 2013 through December of 2013 will be added to your Comp Time Bank in February of 2014 (Commanders and above under Occasional Time Off). Earned points cannot be carried over to the following year. Days off are calculated as 8 hour days (Comp Time awarded as 8 hours straight time).

Quarters & Due Dates

1st Qtr is January 1st to March 31st -	Signed Tally Sheets are due by April 15th
2nd Qtr is April 1st to June 30th -	Signed Tally Sheets are due by July 15th
3rd Qtr is July 1st to September 30th -	Signed Tally Sheets are due by October 15th
4th Qtr is October 1st to December 31st -	Signed Tally Sheets are due by January 15th

At the end of each quarter, employees are responsible for completing a ***signed*** Tally Sheet (see Page 13). Attach documentation to the Tally Sheet.

The Tally Sheet and documentation may be scanned and emailed, or sent inter-department mail, to Technician Danny Veith (Room 502).

Personal, private medical information is not needed. A doctor's note, invoice for services, co-pay, insurance history,… will suffice.

Mandatory for 2013!

The ***Annual Physical Exam*** (page 6), and the ***Online Health Assessment*** (Page 9) are both mandatory activities in 2013.

To earn points this year, both of these activities must be completed between January 1st and December 31st!

The Online Health Assessment may be easier to complete ***after*** your Physical & Dental Exams.

Summary

Health can be defined as the state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.
Wellness is more than just a lack of illness. It is a state of being in which the mind, body, and spirit are in balance and functioning in their optimal states. Wellness is not limited to a healthy diet and exercise; the mind, body, and spirit are integrated and inseparable.
The ***2013 Wellness Rewards Program*** is designed to encourage responsibility for one's own health, through preventative care and healthy activities. The more activities you participate in, outlined on the following page, the better your opportunities to thrive, to be healthy and well.

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Physical Exam: 50 Points (Mandatory in 2013)

Even if you feel fine, and you are in good health, an annual physical exam with your doctor is very important. Consider the fact there are usually no signs or symptoms for hypertension, a heart murmur, high cholesterol, and many other diseases. An annual physical exam is necessary to detect potential threats to your health.

A thorough exam involves a review of your health during the past year; checking your vital signs (blood pressure, heart rate, respiration rate, & temperature); examination of your heart, lungs, head / neck, abdomen, skin, & extremities; and laboratory tests (blood count, blood sugar, chemistry panel, urinalysis, & lipid panel for cholesterol levels). Just as important, your doctor has an opportunity to get to know you as you discuss concerns, your overall health, weight, exercise regimen, use of tobacco or alcohol, and ideas to stay healthy during the up-coming year.

Remember to keep track of your vital signs and cholesterol levels for the on-line Health Risk Assessment with your insurance provider (Page 9).

See your own personal physician for your annual routine preventative care exam (per your current plan with United Health Care or Kaiser Permanente) and earn 50 Points.

Annual Mental Health Check: 50 Points

Seeing your doctor, dentist, and eye doctor each year is a choice, a preventative task and decision you make to stay healthy. Obtaining an immunization shot for tetanus, hepatitis B, and the flu is also a choice, an inoculation for toxins you may be exposed to during the course of your duties.

An annual mental health check is also a choice, and no one has to know about it. Whether or not you indicate it on a Tally Sheet, and earn 50 points, the annual mental health check provides an opportunity to review your health during the past year with a therapist. Reviewing concerns or issues in your personal and professional life creates a foundation for learning and growing, and to prepare for future exposure to trauma. Goals can be set for the upcoming year in areas such as stress management, diet, exercise, sleep, and relaxation.

Problem areas, such as relationship issues, alcohol abuse, interpersonal issues with peers or supervisors, difficulty sleeping, financial problems, etc can be identified and addressed. With the help of a therapist, strengths and techniques can be developed for improved health. Just as with your medical doctor, annual mental health checks will generate a relationship with your therapist, allowing you to benefit from preventative mental health, resiliency, and hardiness during your career.

See your own personal therapist (per your current plan with United Health Care or Kaiser Permanente), or a Psychologist at Nicoletti-Flater (OEA for CSA) and earn 50 Points.

Dental Preventative Exam / Cleaning: 25 - 50 Points

Earn points for up to two routine oral examinations and cleanings each year. No matter how diligent you are in your home dental care regimen, you should still get a dental exam and cleaning twice per year. Prevention and early detection are the key to avoiding tooth decay and gum disease. Regular dental cleanings are a crucial part of preventative dental care.

Early detection makes treatment easier, less expensive, and more effective. In your twice-yearly dental exam, your dentist should perform the following routine checks:

- Examine and assess gum health; test for gum disease
- Examine any existing tooth decay
- Take and analyze x-rays, which may reveal decay, tumors, cysts, and other problems
- Screen for the presence of oral cancer
- Verify the stability of any existing fillings or other restorations

See your personal dentist for your twice-yearly preventative exam and cleaning per your current plan to earn 25 Points per visit. Maximum 50 Points each year (2 visits).

Eye Exam: 25 Points

Routine eye examines are important, regardless of your age or your physical health. During a comprehensive eye exam, your eye doctor does more than just determine your prescription for eye glasses or contact lenses. He or she will also check your eyes for common eye diseases, assess how your eyes work together as a team and evaluate your eyes as an indicator of your overall health.

Earn 25 Points for completing an annual eye exam.

Colonoscopy: 25 Points

A colonoscopy helps find ulcers, colon polyps, tumors, and areas of inflammation or bleeding. During a colonoscopy, tissue samples can be collected (biopsy) and abnormal growths can be taken out. Colonoscopy can also be used as a screening test to check for cancer or precancerous growths in the colon or rectum (polyps). Doctors recommend routine testing for people age 50 and older who have a normal risk for colorectal cancer. People with a higher risk should be tested sooner. Talk to your doctor about when you should be tested.

Earn 25 Points for completing a colonoscopy.

Mammogram: 25 Points

A mammogram is a low-dose x-ray exam of the breasts to look for changes that are not normal. The results are recorded on x-ray film or directly into a computer for a doctor called a radiologist to examine. A mammogram allows the doctor to have a closer look for changes in breast tissue that cannot be felt during a breast exam. It is used for women who have no breast complaints and for women who have breast symptoms, such as a change in the shape or size of a breast, a lump, nipple discharge, or pain. Breast changes occur in almost all women. In fact, most of these changes are not cancer and are called "benign," but only a doctor can know for sure. Breast changes can also occur monthly, due to your menstrual period. Women over 40 years and older should get a mammogram every 2 years. Talk to your doctor about when to start and how often you should have a mammogram.

Earn 25 Points for completing a mammogram.

Heart Scan: 25 Points

Document undergoing a 64-slice (multi-detector computed tomography) heart scan during the year for 25 Points. An ultrasound of the carotid and or brachial arteries is not the same as a heart scan.
As you may recall, the Denver Police Foundation, in cooperation with Porter Hospital, provided funding for a 64-slice CT heart scan to attain a calcium score. Every qualifying DPD officer was offered the heart scan, under the Healthy Heart Hero Program, by invitation between July of 2010 and October of 2012.
Now that every qualifying officer has had the opportunity to take advantage of the offer, it is unclear if the Denver Police Foundation will continue to fund this project (they are evaluating this option).
In the meantime, Porter Adventist Hospital continues to provide $200 heart scans for qualified Denver Police officers. "Qualified" means an active-duty officer that 1) has not had a heart scan during the last 5 years; 2) a male 35+ years of age, or female 45+ years of age; or 3) possesses a risk factor for heart disease (family history, hypertension, hyperlipidemia, diabetes,…). Schedule a heart scan, advising Porter you are a DPD officer and will be paying with your own funds. Prior to your scheduled heart scan, please complete the health history and demographic forms which can be found at www.porterhospital.org/dpdheart .

Earn 25 Points for completing a 64-slice CT Heart Scan in 2013.

Sleep Study: 25 Points

About 42 million Americans have some form of sleep-disordered breathing (about 85% go untreated). The most common is obstructive sleep apnea (OSA) which affects nearly 1 in 5 adults. OSA sufferers are at a higher risk for heart disease, high blood pressure, type 2 diabetes, depression, and weight gain.

Earn 25 points when your primary care physician makes a referral to a sleep center and you complete a sleep lab.

Online Health Assessment: 25 Points *(Mandatory in 2013)*

This free, online assessment is completed with your health care provider (United Health Care, Kaiser Permanente, or Denver Health). The assessment is a health questionnaire about exercise, eating habits, preventative health behavior, etc. The information you provide on the assessment is accessible to you and your health insurance provider only - neither the City & County of Denver nor the Police Department will have access to your medical information. Recorded information, from your last physical exam, dental preventive exam, and or the health fair will assist you in completing the online assessment.

- UnitedHealthcare members link here for Online Assessment.
- Kaiser Permanente members link here for Online Assessment (on the DPD WEB, click "Health" along the left column and look for a step-by-step guide prepared by KP).
- Denver Health members link here for Online Assessment.

Earn 25 Points by completing the online assessment with your insurance provider; print out the "successfully completed the assessment…" page as proof.

Body Composition Assessment: 25 Points

Your bathroom scale and BMI charts fail to account for lean muscle; and skin fold measurements (using calipers to calculate body fat) can vary greatly.

The Bod Pod is an air displacement plethysmograph which uses whole body densitometry to determine body composition (fat and fat-free mass). It is based on the same principle as underwater weighing (the accepted gold standard for measuring body composition). The Bod Pod uses a patented air displacement technology to provide highly accurate results more quickly and easily than the dunk tank.

Ladies can bring any combination of form fitting swim wear, and or tight fitting bike shorts and sports bra. Men can bring swim trunks, but tight fitting shorts (such as Lycra bicycle / compression shorts) are preferred. It's best not to exercise or eat within two hours of your appointment (drinking water is OK), and the entire process takes less than 15 minutes.

Dr. Sandusky (3520 W. 92nd Ave) is offering the Bod Pod Test to DPD employees for just $25. You will be alone, in a private room, to conduct the Bod Pod Test by yourself. Call 303-426-5600 for an appointment (and tell her you are with DPD). You will receive a printout of your weight, percentage of lean mass, and percentage of body fat.

Hydrostatic Body Fat Testing (Hydro-Densitometry), also known as a "dunk test" (because underwater immersion takes place), is an acceptable alternative to the Bod Pod.

Earn 25 Points (once) with documentation of body composition assessed by an air or water displacement test in 2013 (we do not need your weight / fat percentage measures).

Tom O'Byrne Health Fair: 25 Points

The *Tom O'Byrne Health Fair* occurs in October of each year at the PPA. Employees receive "health bucks" that can be used towards immunizations, blood draws / test screens, and other services. This is a perfect opportunity to know your numbers, that is to compare measurements (waist, weight, blood pressure, heart rate,…) and numbers (Total Cholesterol, LDL, HDL, Glucose,…) with the measurements and numbers obtained earlier in the year during your physical exam. Have you made progress towards a better state of well being?

Earn 25 Points by attending and participating in at least one screening (health bucks provided at the health fair).

911 UTC (Fitness Challenge): 25 - 50 Points

Our annual Fitness Challenge - the ***911 Ultimate Transformation Challenge*** - is currently administered by iSatori Technologies. The Challenge is usually offered twice a year, and participants can earn 25 points per completion of every Challenge.

iSatori's goal is to assist fire fighters, law enforcement officers, and paramedics achieve their best physical shape. iSatori is not concerned about your gender, age, whether you are thin and want to gain a lean, muscular physique, or overweight and want to strip off unhealthy body fat; their goal is to help you transform your current condition to a level of peak performance.
The first challenge (12 weeks in duration) begins in January, 2013. A subsequent Challenge can be 8 or 12 weeks in length and occurs later in the year.

Watch for announcements in the Daily Bulletin. iSatori does not require participants to use their products and services; iSatori staff is available, however, to answer your questions about diet and supplement use during the Challenge (1-866-688-7679). See also www.911utc.com

Earn 25 Points by completing iSatori's 911UTC (complete both the sign-up / weigh in / registration and the final weigh out).

Wellness Continuing Education: 15 Points

Officers and employees can accrue 15 Points for every 4-hours of attendance at a Wellness related training session or lecture. These courses are offered at the Police Academy, presenters provided by ***Denver Wellness***, and outside resources such as Colorado POST, CRCPI, Kaiser Webinars, outside agencies, etc. As an example, an employee could attend four 1-hour Wellness lectures during the year to accrue 15 Points; attending an 8-hour CEP Class at the Academy (concerning Wellness) would be the equivalent of 30 Points.

Gym / Fitness Center Attendance: 25 - 100 Points

How frequently you should exercise is determined by several fitness and health factors such as age, health condition, and fitness-level. The fitter and healthier you are, and the more ambitious your performance goals, the more often you can workout. While two workouts per week (about 30 minutes in duration) will maintain basic fitness and health, three to five workouts a week are necessary to raise your fitness level and help you achieve goals. For instance, weight / resistance training should occur two to three times a week and cardiovascular / aerobic training four to five times a week.

For the purpose of *Wellness Rewards*, attending a gym / fitness center approximately 4 times a week per quarter (52 visits) accrues 25 Points.

Your workout can consist of any resistance or aerobic activity (or combination) for at least 30 minutes (not including time to stretch / warm up before your workout, and time to cool down at the end). A round of golf, a day hike, a day of skiing or snowboarding, etc can be substituted for that day's gym attendance.

Most gym / fitness centers can produce an attendance report based on your member ID card scans at each visit. Otherwise, employees will keep a log of their attendance at a District Station or home (see Page 14).

To earn 25 points per quarter, attach a Gym / Fitness Center Log or other documentation demonstrating a minimum of 52 sessions during the quarter.

Organized Events: 10 - 100 Points

Employees who enter and complete an organized athletic event can accrue at least 10 Points per event. In the past, as a gauge, these points have been awarded for completing these events:

Triathlon (750 M swim, 20K bike, 5K run)	25 points;
Triathlon (1.5K swim, 40K bike, 10K run)	75 points;
Triathlon (1.9K swim, 90K bike, 21K run)	100 points;
MS 150	50 points;
Marathon (26 miles)	25 points;
Elephant Rock 100 miles	50 points;
Elephant Rock 62 miles	25 points;
Elephant Rock 34 miles	15 points;
Elephant Rock 25 miles (fat tire)	15 points;
Elephant Rock 7 miles (family)	10 points;
Moonlight Classic	10 points;
10K Run	15 points;
5K Run	10 points;
Warrior Dash	25 points;
Fun Events (i.e. softball or hockey tournaments, etc)	15 points; (continued next page)

Organized Events: continued….

Muddy Buddy	15 points;
Tough Mudder	20 points;
Battle of the Badges & Hero Challenge	50 points;
America on the Move*	10 points:
Self Paced Physical Challenge*	10 points;
Health Plate (Nutrition Challenge)*	10 points.

- CSA employees: if you are interested in being eligible for a wellness credit on your pay-check in 2014, you must complete either the Stairwell Challenge or the Self Paced Challenge (if you did not participate in America on the Move last Fall) in addition to a Nutrition Challenge (Healthy Plate or Weight Watcher's "At Work Program"). More information can be found by at -www.denvergov.org/denverwellness or by clicking here.

Annual Physical Fitness Test: 150 - 300 Points

The Physical Fitness Test is based on the U.S. Army's "APFT" (Army Physical Fitness Test). Participants must score a minimum of 50 Points in each of the three tests: Two Mile Run, Push-Ups, and Sit-Ups. If a participant fails to obtain at least 50 Points in one category, despite high scores in the other two, no points can be obtained for ***Wellness Rewards.*** A maximum of 100 Points can be obtained in each of the three tests; your total points attained in the APFT convert to the same ***Wellness Rewards*** points.

The Physical Fitness Test measures the number of Push-Ups completed in a two minute period, the number of Sit-Ups completed in a two minute period, and your time in a Two-Mile Run. The scores, from each of these events, are adjusted for gender and age. As an alternative to the two-mile run, a stationary bicycle is an alternative (6.2 miles at 2 kilograms of tension, time adjusted to age and gender). The stationary bicycle segment is "pass-fail," meaning you can either earn 50 points (pass) or 0 points (fail).

Participants can take the test, at the Denver Police Academy, on the days listed below (one hour converted to ninety minutes of Comp Time can be attained for participating in each test). Participants can obtain Comp Time for participating in up to four tests between January 1st and December 31st. **Only the best total score**, ***from one test session / day***, can be used to attain points (150 to 300) for the year in this ***Wellness Rewards*** program.

Information about the APFT and Male / Female Charts can be found here and the DPD WEB by clicking "Health" on the left column.

The Academy will host test dates each quarter, and two times for testing each day (1000 hours and 1400 hours). **Monday, March 4th** **Tuesday, June 11th**

Wednesday, August 28th **Thursday, December 5th**

Appendix L

2013 Wellness Rewards Tally Sheet

Quarter -

□ First (January 1st thru March 31st) □ Second (April 1st thru June 30th)

□ Third (July 1st thru September 30th) □ Fourth (October 1st thru December 31st)

Name_____ **Badge/ID#**_____

Signature_____ **Assignment**_____

(My signature affirms all information reported is true and accurate)

Activities / Events Completed this Quarter -

□ Physical Exam (Primary Care Physician) 50 pts	□ Online Assessment (through health care plan) 25 pts
□ Mental Health Check (Psychologist) 50 pts	□ Body Composition Assessment (Bod Pod) 25 pts
□ Dental Preventative Exam / Cleaning 25 pts	□ Tom O'Byrne Health Fair at PPA 25 pts
□ Annual Eye Exam 25 pts	□ iSatori 911 UTC (Completed this Quarter) 25 pts
□ Colonoscopy 25 pts	□ Wellness Continuing Education 15+ pts
□ Mammogram 25 pts	□ Gym / Fitness Center Attendance 25 pts
□ Heart Scan (64-Slice CT for Calcium Score) 25 pts	□ Organized Event 10+ pts
□ Sleep Study (Physician referral to Lab) 25 pts	□ Army Physical Fitness Test 150 - 300 pts

Total Points _____

Check off list for documentation -

□ Co-Pay Receipt / Doctors Note (or similar documentation) for physical exam, dental exam, procedure, test,…

□ Gym / Fitness Center Attendance Log

□ Denver Police Academy U.S. Army Fitness Test Score Sheet

□ Certificate of Attendance / Documentation for Continuing Education related to Wellness (with total hours)

□ Documentation regarding completion of ***Denver Wellness*** event (Stair Well Challenge, Healthy Plate,…)

□ Photocopy of bib number, documentation of race results,… for Organized Event (list distance of event)

Signed Tally Sheets, and documentation, are due on the 15th of April, July, October, and January. Please scan or inter-department mail Tally Sheets and documentation to Technician Danny Veith (Rm 502 at HQ).

Gym/Fitness Center Attendance Log

Name:_________________________________ Badge/ID:_____________

For the purpose of earning Wellness Rewards, attending a gym / fitness center approximately 4 times a week per quarter (52 visits) accrues 25 Points. Your workout can consist of any resistance or aerobic activity (or combination) for at least 30 minutes (not including time to stretch / warm up before your workout and time to cool down at the end). Most gyms / fitness centers can produce an attendance report based on your member ID card scans at each visit. Otherwise, employees will keep a log of their attendance at a District Station or home gym. **See Page 11 for more details**.

Reporting Quarter

☐ **Jan – March 2013** ☐ **April – June 2013** ☐ **July – Sept 2013** ☐ **Oct – Dec 2013**

DATE:___________ LOCATION: _______________ _ o Minimum 30 Minutes	DATE:___________ LOCATION: _______________ _ o Minimum 30 Minutes	DATE:___________ LOCATION: _______________ _ o Minimum 30 Minutes	DATE:___________ LOCATION: _______________ _ o Minimum 30 Minutes	DATE:___________ LOCATION: _______________ _ o Minimum 30 Minutes	DATE:___________ LOCATION: _______________ _ o Minimum 30 Minutes
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Findings of the Policy Advisory Sub-Committee

We are all familiar with the adage attributed to Benjamin Franklin, "An ounce of prevention is worth a pound of cure." Considering how debilitating a disorder PTSD is, prevention is truly better than cure.

The Enabling Act that created this Task Force directed members to make recommendations concerning best policies and practices in the area of preventing duty-related PTSD. Selected members were assigned to an Advisory Policy Sub-Committee to identify gaps and make recommendations in this area. This Sub-Committee, chaired by John Nicoletti, Ph.D., ABPP, focused on three areas for trauma awareness, mitigation, and recovery:

1. Pre-Event Horizon – The phase before an officer has experienced trauma exposure;
2. Event Horizon – The phase when the officer has either experienced acute or long term trauma exposure;
3. Post Event Horizon – The phase in which the officer has either developed PTSD or is experiencing significant traumatic reactions due to intrusions and flashbacks.

The Advisory Sub-Committee created two surveys. One survey was for Chiefs, Sheriffs, and CEOs of law enforcement agencies, and the other was for peace officers. The sub-committee asked that the surveys be distributed to as many agencies and officers as possible. The surveys were voluntary and not a scientific sample of the law enforcement population; only about 10% of the state's peace officers responded. Nevertheless, the surveys did provide important feedback and thoughts, data that reinforced existing opinions of members on the Advisory Policy Sub-Committee.

Each phase was analyzed according to the Issues and challenges present at each time segment, gaps between issues, and available programs and countermeasures to mitigate the gaps.

Selection of Officers and Employees

The importance of pre-employment screening was discussed during Task Force meetings. A pre-employment psychological evaluation is a specialized examination of an applicant's psychological suitability for a public safety position. Psychological suitability includes, at a minimum, the absence of job-relevant mental or emotional conditions that would reasonably be expected to interfere with safe and effective performance.[1]

Pre-employment screening is a critical step during the hiring process for peace officers, but also for civilian personnel employed in law enforcement capacities (e.g., dispatch, detentions, crime scene, victim's assistance, etc). This latter group may be overlooked by some agencies during this process. The Task Force agreed Colorado law enforcement agencies should be encouraged to consult and be guided by the International

[1] Pre-Employment Psychological Evaluation Guidelines, Ratified by the IACP Police Psychological Services Section, Denver, Colorado, 2009 at http://www.theiacp.org/portals/0/documents/pdfs/Psych-PreemploymentPsychEval.pdf

Association of Chiefs of Police (IACP) Pre-Employment Psychological Evaluation Guidelines Ratified by the IACP Police Psychological Services Section here, in Denver, in 2009.

Because they will be exposed to traumatic events during their career, it is vital agencies seek out and hire healthy personnel. The Advisory Sub-Committee is aware agencies recruit officers and personnel from diverse backgrounds and life-experiences (because these characteristics enhance an ability to interact and work with their community on crime and social issues). Both officers and agencies should be aware, however, that unresolved life issues can become a liability if not properly acknowledged and addressed. See "Pre-Employment Screening" later in this chapter for further discussion.

Officer Self-Awareness

Certain vulnerabilities, sometimes called "Pre-Trauma Vulnerabilities," become risk factors for the development of PTSD. For example, officers who experienced childhood abuse are at an increased risk to develop PTSD following exposure to duty-related traumatic events (present traumas are likely to reactivate unresolved traumas from the past). [2] It is important, therefore, that individual officers become aware of their unique personality in order to inoculate themselves in preparation for the inevitable exposure to duty-related traumatic events. Officers should also follow up by learning and applying skills to enhance their individual resiliency (thus minimizing the risk to develop PTSD). It is equally important for agencies to provide their peace officers with both initial training in an Academy setting, and continuing training (during an officer's career) with courses concerning trauma awareness (including vicarious trauma) and inoculation.

Inoculation

The Advisory Sub-Committee discussed both stress inoculation and emotional inoculation as training that would increase resiliency while resisting (or, at the very least, mitigating) the onset of PTSD.

For example, Advisory Policy Sub-Committee member Officer Danny Veith described how his agency introduces awareness in trauma triggers/symptoms and inoculation training for new Recruit Officers in the Academy. This was done by his agency's Peer Support Providers, who also followed up during the Academy's 6-month schedule with further instruction by Psychological Services. Using a model described by Glenn R. Schiraldi, Ph.D.,[3] Peer Support Providers discuss with Recruit Officers the emotional challenges (in addition to the physical challenges) they will face during a 30-year career. During the first week of the Academy, Recruit Officers are exposed to small doses of emotional stress in the controlled setting of a classroom. The expected outcome

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[2] Schiraldi, G. (2009). *The Post-Traumatic Stress Disorder Sourcebook: A Guide to Healing, Recovery, and Growth* 2nd ed., McGraw-Hill Books

[3] Schiraldi, G. (2009). *The Post-Traumatic Stress Disorder Sourcebook: A Guide to Healing, Recovery, and Growth* 2nd ed., McGraw-Hill Books

is that they will gradually build emotional strength during their remaining time in the Academy. This is accomplished by showing the documentary film *"Heroes Behind The Badge"*[4] with a worksheet that requires each Recruit Officer to: 1) consider the facts surrounding each line-of-duty death, 2) consider how they would likely respond to the portrayed event (e.g. what would they think, feel, and do before, during, and after), 3) consider how they think most officers would respond during the event (thoughts, feelings, and behaviors), 4) consider what they believe would an ideal response to the event, and 5) consider how they would feel if their response was less than ideal. The experienced Peer Support Providers providing this three-hour presentation discuss a range of coping options and resources the students may have not considered. During the remaining five months of the Academy, psychologists from the Department's Psychological Services have opportunities to delve deeper into trauma awareness (including vicarious trauma), inoculation, and resilience.

Emotional Self-Care

The Task Force heard testimony from Ron Clark, the Chairman of the Board for *The Badge of Life.* The cornerstone of this program is a new approach to suicide prevention called the Emotional Self-Care Program (ESC). The Founder of *Badge of Life*, Andy O'Hara,[5] describes the ESC Program below.

The Emotional Self-Care (ESC) Program is based on two simple principles: First, each officer will be responsible for his or her own emotional well-being. Second, the agency is responsible for the career long training, tools, and resources with which an officer can meet that responsibility.[6] In 2011, Andy O'Hara described ESC as a new training approach. O'Hara acknowledged that every police officer is a potential trauma victim – every workday. With this fact in mind, ESC training is both a prevention and fitness program to involve every officer (not just those at risk or currently experiencing psychological distress). One can compare ESC to the two-prong approach of maintaining physical health: 1) engaging in physical exercise and 2) seeing your primary care physician for an annual exam. ESC involves Annual Training and an Annual Mental Health Check. The renewed interest and research in mind-body medicine supports efforts, such as ESC, for resiliency where thoughts and emotions can influence physical health.

The annual training enumerated by O'Hara involves defining the triggers and early symptoms of trauma, recognition, immediate and long-term measures, stress management, resilience, and healthy lifestyles (all identified by this Task Force's

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[4] Erfurth, B. (Executive Producer), & Derrick, W. (Director). (2012). *Heroes Behind The Badge* [Motion picture]. United States: Modern City Entertainment.

[5] Andy O'Hara is a past Executive Director, and current Advisor, for *Badge of Life* (the Task Force heard testimony from Ron Clark, the current Chairman of the Board for *Badge of Life*). A military veteran as well as a 24 year officer and sergeant of the California Highway Patrol, Andy is a POST certified advanced peer support officer. He was retired from his police career with PTSD and was suicidal. As the founder of *Badge of Life*, Andy was highlighted by Forbes Magazine as one of eight notable retirees founding charitable organizations.

[6] Violanti, J., O'Hara, A., & Tate, T. (2011). *On The Edge: Recent Perspectives on Police Suicide*. Springfield, Illinois Charles C. Thomas Publisher Ltd.

Advisory Policy Sub-Committee). The annual Mental Health Check with a mental health professional is described by O'Hara as voluntary, confidential, and without reporting or accountability to the officer's agency. Anywhere from 60 to 90 minutes in length, the officer and mental health professional discuss the past year's events in the officer's life at work and at home. The officer picks out events that were emotionally challenging and evaluates the appropriateness of his or her response with the mental health professional. This provides the officer with an opportunity to learn and grow (another form of inoculation for future trauma). Previously undisclosed traumatic work experiences may be identified, discussed, and addressed (rather than allowing them to fester). The officer and mental health professional wrap up this annual session by setting goals for the upcoming year (e.g., what triggers the officer needs to remain aware of, tools and resources that will work best for future trauma exposure, identifying and addressing problem areas at home and work, developing and enhancing resiliency, etc).

Applying ESC to a Wellness Program

Advisory Policy Sub-Committee member Officer Danny Veith described how ESC was incorporated in to the *Wellness Rewards Program* he developed for his agency.[7] Operating without a budget, the *Wellness Rewards Program* allows officers to earn points for healthy activity. These points can be exchanged at the end of each year for time off (Comp Time). In addition to earning points for activities such as regular exercise, getting an annual exam with a doctor and dentist, and obtaining preventative screenings, officers earn points for participating in an annual Mental Health Check. The chair of the Advisory Policy Sub-Committee, John Nicoletti, Ph.D., ABPP, remarked on his personal experiences with this program, pointing out the success of this incentive for officers to see a mental health professional at least once a year. The stigma of "seeing a shrink" was greatly reduced, and officers have begun to develop a relationship (which can potentially last throughout their career) with a therapist.

Wellness Programs to Prevent or Mitigate PTSD

The *Wellness Rewards Program* was designed by acknowledging that illnesses like PTSD rarely occur alone. Typically, a person with PTSD will also experience depression, anxiety, and/or substance abuse disorder. Additionally, individuals with PTSD are more likely to develop a medical disorder such as irritable bowel syndrome, fibromyalgia, chronic fatigue, headaches, chronic pain, gynecological complaints, psoriasis, rheumatoid arthritis, metabolic syndrome, ulcers, eating disorders, obesity, and thyroid diseases. Unresolved trauma has even been found to predict coronary heart disease, high blood pressure, and cancer. Even among those whose traumatic symptoms are not severe enough to warrant a PTSD diagnosis, emotional suffering such as depression, anxiety, nightmares, and suicidal thoughts, can still occur.[8] It is important,

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[7] Veith, D. (2013). *2013 Wellness Rewards Guidelines.* Denver Police Department's *POWER* (Police Officer Wellness & Employee Resources).

[8] Schiraldi, G. (2011). *The Complete Guide to Resilience: Why It Matters, How to Build and Maintain It.* Ashburn, Virginia Resilience Training International.

therefore, that agencies have a wellness program in place that not only provides officers and employees with training in awareness, prevention, and management, but also encourages them to seek assistance from medical and mental health professionals, when necessary, in addition to obtaining screenings at appropriate intervals during their careers. Exercise, good nutrition, and sufficient sleep combine to enhance brain health (which, in turn, improves resilience). Resilience is a necessary skill to prevent PTSD. Training and skills in resiliency need to be a major component of an agency's wellness program (beginning in the Academy and continuing throughout the officer's career).

Resilience and Post-Traumatic Growth

Any peace officer who is exposed to traumatic events while simultaneously employed in a high-stress occupation may experience any one of three outcomes: 1) the development of PTSD, 2) at the other end of the spectrum, Post-Traumatic Growth (PTG), and 3) resilience. Of course, avoidance of PTSD all together is ideal - thus the emphasis on resilience in this section of the report.

Officers and law enforcement agencies are becoming more familiar with the term "resilience," which can be defined as an officer's capacity to draw on resources and competencies to manage demands and challenges. It can be described as the capability to bounce back following exposure to adversity. Another way to define resilience is the positive outcome after exposure to trauma, whereby an officer rapidly returns to baseline functioning. With PTSD as one bookend and Post-Traumatic Growth the other, one can see why resilience is on the positive end of this spectrum.

Can an exclusive focus on PTSD shape expectations among peace officers about what they believe will happen after traumatic exposure? In an unpublished survey conducted at the U.S. Military Academy, West Point, 100 cadets in their junior and senior years were asked about their knowledge of PTSD and Post-Traumatic Growth (PTG). As juniors and seniors, these cadets had a considerable education and training about military issues: 80% were confident that they understood PTSD well and yet in stark contrast, 78% had never heard of PTG. Of those who had heard of PTG, only 2% were confident in their understanding of it. Moreover, 85% indicated they had received explicit training on PTSD since arriving at West Point, compared with just 18% claiming some degree of training about PTG. Perhaps most alarming, only 22% of these highly educated and motivated future officers believed they "would not" or "most likely would not" develop PTSD following a future combat deployment. Just as with other depressive and anxiety disorders, the authors note, such expectations can be self-fulfilling.[9]

In the aforementioned survey of Colorado peace officers, 20% indicated that they had heard of the concept "Post-Traumatic Growth." PTG refers to a change in people that goes beyond a return to previous functioning and involves a movement beyond pre-trauma levels of adaptation.[10] The term PTG was coined by Richard Tedeschi, a psychologist at the University of North Carolina, Charlotte, who is both a researcher and

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[9] Cornum, R., Matthews, M., & Seligman, M. (2011). Comprehensive Soldier Fitness: Building Resilience in a Challenging Institutional Context. *American Psychologist, 66* (1), 4-9.

[10] Tedeschi, R. & Calhoun, L. (2003). *Promoting Capabilities to Manage Posttraumatic Stress: Perspectives on Resilience.* Springfield, Illinois Charles C. Thomas Publisher Ltd.

a clinician, and Lawrence Calhoun, who is also a psychologist at U.N.C. From a paragraph in the New York Times Magazine, the dynamics of PTG are described:

> Only a seismic event — not just an upsetting experience — can lead to this kind of growth. By that Tedeschi means an event that shakes you to your core and causes you to question your fundamental assumptions about the world. Survivors of such severe trauma inevitably confront questions about existence that most of us avoid, and the potential for growth comes not from the event itself but from the struggle to make sense of it. Tedeschi calls this rumination, and he argues that it can happen alongside P.T.S.D., after P.T.S.D. or in its absence. 'The challenge is to see the opportunities presented by this earthquake,' Tedeschi says. 'Don't just rebuild the same crappy building you had before. Why not build something better?'[11]

PTG does not occur as a direct result of the traumatic event, resilient people are less likely to experience it, and it is the individual officer's struggle with the new reality that determines the extent to which PTG occurs. Tedeschi and Calhoun have found evidence that indicates an officer's initial attempts to understand what has happened, followed by deliberate attempts to interpret the aftermath positively (and bring benefits to mind), are reliably related to PTG. Mental health professionals, especially those familiar with the law enforcement culture, can facilitate PTG by remaining patient throughout the entire process (goal disengagement; automatic, homeostatic cognitive processing; benefit finding; and later, benefit reminding).

Tedeschi and Calhoun point out that it may be useful to introduce the concept of growth arising from the struggle at some point in the process, as it may not be obvious to many officers). The possibility of PTG must be introduced somehow, and for many survivors the most credible sources are veterans of similar circumstances (such as members of Peer Support).

The Post-Traumatic Growth Inventory (PTGI) measures five domains for growth: a greater appreciation of life, closer relationships, identification of new possibilities, increased personal strength, and positive spiritual change. Jenna Van Slyke, M.S., of the Naval Center for Combat & Operational Stress Control, explains PTG as:

> Greater appreciation of life following a traumatic event can be represented by a shift in priorities and taking pleasure in aspects of life that were once taken for granted. Trauma survivors may also experience increased compassion and empathy for others, which allow them to cultivate deeper and more meaningful relationships. Identification of new possibilities and increased personal strength can also be seen in trauma survivors who display high levels of PTG. For example, an individual may display higher levels of self-efficacy or a stronger belief in his or her ability to overcome obstacles. The same individual may experience a change in values post-trauma and find that he or she is able to identify a more fulfilling path for the future. Finally, trauma survivors may also

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[11] Rendon, J. (March 22, 2012). Post-Traumatic Stress's Surprisingly Positive Flip Side. *The New York Times Magazine.* *http://www.nytimes.com/2012/03/25/magazine/post-traumatic-stresss-surprisingly-positive-flip-side.html?pagewanted=all&_r=0*

> experience a positive change in spirituality, perceiving themselves as being more capable of connecting with something greater than themselves (God, the universe, nature, etc.), regardless of religious affiliation.[12]

Resilience can be taught and acquired. PTG can occur with facilitation by mental health professionals and Peer Support providers who are familiar with the law enforcement culture. Through awareness and training, the law enforcement culture may be able to alter the expected outcome of PTSD after exposure to a "seismic event" to create a self-fulfilling outcome of resilience and post-traumatic growth.

Peer Support

Peer Support has been previously discussed and is a crucial component of prevention, from training new Recruit Officers at the Academy to assisting seasoned officers during the aftermath of a traumatic event.

The International Association of Chiefs of Police (IACP) defines the goal of peer support as:

> To provide all public safety employees in an agency the opportunity to receive emotional and tangible support through times of personal or professional crisis and to help anticipate and address potential difficulties. Ideally, peer support programs are developed and implemented under the organizational structure of the parent agency. For a peer support program to work effectively, it must have support from the highest levels within an organization.[13]

Peer Support Programs are staffed by Peer Support Providers (PSPs) operating under the supervision of a mental health professional. PSPs are permanent, paid department employees who have been specially trained to assist fellow employees by providing services such as information, guidance, advice, referrals, consultation, and liaison with healthcare professionals. PSPs render these services voluntarily in addition to their regular work assignments. At the discretion of their supervisor(s), they may conduct Peer Support activities while on duty provided that this does not interfere with their regular work assignments, violate department policies or procedures, or otherwise disrupt department operations. PSPs do not provide professional services such as diagnosis or treatment of mental disorders, psychological assessment, testing, counseling, or any other activity that might constitute the practice of psychotherapy under the Colorado Revised Statutes or other applicable laws.[14]

Peer Support is an intervention that takes advantage of shared experiences to foster trust, decrease stigma, and create an environment for officers and employees to seek help and share information (such as positive coping strategies and resources).

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[12] Van Slyke, J. Post-traumatic Growth. Naval Center for Combat & Operational Stress Control. http://www.med.navy.mil/sites/nmcsd/nccosc/healthProfessionalsV2/reports/Documents/PTG_WhitePaperFinal.pdf

[13] Peer Support Guidelines, Ratified by the IACP Police Psychological Services Section, Chicago, Illinois, 2011.

[14] Denver Police Department's Internal Peer Support Policy, revised July 2005.

Officers and employees are more willing to share their feelings and concerns with someone who has had similar experiences. Credibility and trust are critical to building beneficial relationships within a program and in developing positive interactions.[15]

Peer Support Definitions

The term "Client" refers to any agency employee that makes a self-initiated contact, is referred to, or is contacted by a PSP. Any Client, whether sworn or non-sworn, may maintain a mutually consensual peer support relationship with any PSP (sworn or non-sworn).

A PSP is an agency employee specially selected and trained to provide a first line of assistance and basic crisis intervention to fellow employees. PSPs work in a volunteer capacity to assist employees during times of personal and professional crisis. PSPs are trained to recognize situations and events requiring referral of clients to a mental health professional. PSPs may be peace officers (sworn) or civilians (non-sworn). As PSPs interact amongst themselves within the program, rank or position within the department is not a significant consideration. A PSP is usually selected after consideration of characteristics and traits such as reputation within the agency, social skills, ability to empathize, previous education and training, job experience, previous use of a peer support, motivation, sincerity, ability to complete training, and adherence to program policy.

The mental health professional (Police Psychologist) supervises the Peer Support Program for the agency and provides voluntary and confidential services to all employees. The Police Psychologist assists in the selection, training, and retention of PSPs and provides consultation regarding client and other program matters as needed.

Initial and Ongoing Training

Initial training for a PSP often consists of a curriculum that includes instruction concerning mental health, suicide, grief, chemical dependency (and other compulsive behavior), counseling skills, listening skills, issues with families and children, critical incidents, trauma, vicarious trauma, anger management, stress management, and referral techniques.

Peer Support Program Coordinators facilitate regular meetings with their PSPs at a frequency approved by the agency's Chief or Sheriff. The Police Psychologist attends at least a portion of the meeting to provide assistance and consultation in reference to past and on-going contacts with clients. These meetings also provide opportunities for continuing education for PSPs.

Ethical Issues

The behaviors and actions of a PSP reflect on the credibility of the Peer Support Program. Inappropriate behavior can damage the trust fellow employees place in the program.

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[15] Best Practices Identified for Peer Support Programs, Defense Centers Of Excellence (2011), www.dcoe.health.mil

The personal integrity of each PSP and his or her respect for each client's dignity, self-development, and personal welfare is paramount.

PSPs will not exercise power over clients or derive personal gain from helping them. It is unethical for a PSP to accept any gift or remuneration from a client, engage in activities to meet his/her personal needs at the expense of the client, or to ask for favors or help from clients. A PSP's sole reward is the satisfaction of helping a troubled employee.

In developing trust with a client, it is beneficial to explain the PSP's role and describe what services can and cannot be offered. PSPs are primarily caring and attentive listeners, serving as a bridge to helping troubled employees find the professional help they require. They are not tasked with solving the clients' problems for them.

PSPs must be knowledgeable with state statutes and agency policy involving confidentiality. PSPs must advise clients when confidentiality can and must be breached (such as indications of illegal behavior or an indication a clear and imminent danger exists to the client or others), preferably at the outset of any contact.

PSPs must not enter into a "dual relationship" with clients. These can include situations where the client is a subordinate or supervisor, the client is a subject officer or panel member of a Disciplinary Review Board or similar process involving the PSP, the client's need for peer support stems from an incident involving the PSP, and other situations diminishing the PSP's ability to remain objective. PSPs must strive to be neutral, not partisan or aligned with management or employee organizations. The Peer Support Program relies on the trust and endorsement of both management and employees.

PSPs Role in Preventing / Mitigating PTSD

Because they work each day alongside officers and employees, are familiar with the ordinary and extraordinary challenges each are confronted with, and have developed a level of trust, PSPs are in a unique position to monitor the health and well-being of officers and employees before, during, and after traumatic events. PSPs can act as mentors and informal leaders by demonstrating positive coping techniques during and after exposure to trauma. PSPs can also use established trust and confidentiality among their co-workers to encourage and assist those individuals who need additional assistance from a mental health professional to resolve threats to their health and well-being.

Challenges for Smaller Agencies in Rural Areas

The Advisory Policy Sub-Committee is well aware of the challenges smaller agencies – especially those in rural areas of the state – are confronted with concerning the formation of a Peer Support Program and access to mental health professionals familiar with the law enforcement culture.

One possible solution for developing a peer support team would be the formation of a program in a particular geographical area made up of officers and employees from several agencies. The involved agencies (Chiefs, Sheriffs, State Patrol, etc.) could create a policy supported by a mutual aide agreement to allow their officers and employees to seek assistance outside of their agency, with PSPs selected for the regional team. The

policy and agreement would allow for the protected Peer Support communications defined under 13-90-107 of the Colorado Revised Statutes.

Peer Support Programs require oversight by a mental health professional. Within the Colorado Crisis Support Network, mental health professionals (psychologists and social workers) exist in Greeley, Colorado Springs, Alamosa, Glenwood Springs, Pueblo, Frisco, and Grand Junction. These volunteers are familiar with and trained in crisis intervention for emergency services workers.[16] These mental health professionals should be approached to ascertain their eligibility and interest in serving within a regional law enforcement Peer Support Program.

Colorado Crisis Support Network

Often known as CISD or CISM Teams, Colorado is fortunate to have 8 teams in place. These teams are intended to supplement Peer Support Programs (not replace them). PSPs provide on-going assistance with co-workers during the length of their career, whereas Colorado Crisis Support teams provide a one time, one-on-one intervention per critical incident.

Colorado Crisis Support teams provide Defusings and Psychological Debriefings for law enforcement employees and their families when a critical incident occurs. During a large scale/mass casualty incident, these teams can also provide on-scene services and demobilizations/de-escalations for involved personnel. The teams are divided up to serve seven areas of the state.

Agencies are encouraged to contact the team serving their region and become familiar with their services by hosting a Pre-incident education presentation. See https://www.healthoneems.com/conetwork.html for more details.

Summary

Pre-Event Horizon

The Advisory Policy Sub-Committee noted current issues and gaps in the Pre-Event Horizon phase based on discussion, testimony, and the aforementioned survey during the course of Task Force meetings. Some identified issues and gaps are as follows:

- Only 53% of the officers (respondents) indicated their agency currently provides trauma related training;
- Only 44% of respondents (Chief, Sheriffs, etc) stated their agency provides trauma-related training during the Academy;
- Agencies have not conducted or developed policies, procedures, or protocols for assignments (e.g. child porn, child abuse, sex assault, crimes-against-persons, accident reconstruction, etc.) or events (e.g. large scale / mass casualty incidents, mass shootings, etc.) that can potentially produce a traumatic response;
- Agencies may not have available Subject Matter Experts (SMEs) to assist in the Inoculation process;

[16] Colorado Crisis Support Network, Crisis Support Team Resources at https://www.healthoneems.com/conetwork.html

- Some agencies may not have contracts or arrangements in place for a Critical Incident Stress Management (CISM) response; and
- Smaller agencies may not have resources for a Peer Support Program.

The Advisory Policy Sub-Committee suggested countermeasures for these issues and gaps in the areas of training and resource development that have been incorporated into the Task Force's recommendations.

Event Horizon

The Advisory Policy Sub-Committee noted current issues and gaps in the Event Horizon phase based on discussion, testimony, and the aforementioned survey during the course of Task Force meetings as follows:

- Lack of recognition, by an agency, when officers and employees endure trauma;
- Awareness, but lack of insight by officers and employees enduring trauma;
- Officers and employees engaging in denial when enduring trauma (LE culture);
- Lack of guidelines for critical incidents (other than officer-involved shootings);
- Officers and employees reaching out for assistance, but no skilled resources available;
- Stigma concerning officers and employees seeing peer support, employee assistance, mental health professional, CISM Team, etc. following a critical incident; and
- Officers and employees not recognizing the negative impact of social media during traumatic events.

The Advisory Policy Sub-Committee suggested countermeasures for these issues and gaps that have been incorporated into the Task Force's recommendations.

Post-Event Horizon

The Advisory Policy Sub-Committee noted current issues and gaps in the Post-Event Horizon phase based on discussion, testimony, and the aforementioned survey during the course of Task Force meetings as follows:

- According to the aforementioned survey, 15% of the officers who experienced a traumatic event developed significant traumatic stress symptoms and 70% reported experiencing lower level traumatic stress symptoms;
- The traumatic stress symptoms (disorder) endures longer than mental health care coverage or resources;
- Through misunderstanding, an agency and or the public may view debilitating symptoms as malingering;
- Delayed traumatic reactions/symptoms are real and valid, but may be dismissed by the uninformed;
- Traumatic reactions/symptoms can reactivate due to triggering events such as anniversaries, court proceedings months and years later, and when similar events occur;

- PTSD is currently viewed as “part of the job” as opposed to a clear injury as the result of an incident(s);
- Officers and employees have a perception that their identity and personal information will not be kept confidential as they endure and address the traumatic injury they have sustained; and
- Inaccurate assessments when psychologists not familiar with trauma and law enforcement duties / culture, are used for examinations.

The Advisory Policy Sub-Committee suggested countermeasures for these issues and gaps that have been incorporated into the Task Force’s recommendations.

Denver Police Department
Peer Support Program Expansion to Civilian Employees

Purpose

To modify a program that provides every employee within the Denver Police Department the opportunity to receive emotional and tangible peer support through times of personal or professional crisis and to help anticipate and address potential difficulties.

Discussion

As one of the first peer support programs in the United States, Alcoholics Anonymous was founded in 1935 on the belief that a person's peers could offer meaningful assistance in the struggle of alcoholism. Since that time, peer support-based interventions (such as support groups) have helped people cope with a wide range of illnesses and circumstances. The rationale for such groups is that individuals who share a common illness or condition can cope more effectively by discussing their experiences, sharing practical information, and offering moral support to one another.

History

Based on concerns of alcohol abuse and officer suicide, the Denver Police Department Peer Support Project was established in June of 1982. The Program was among the first law enforcement peer support programs in the United States and continues today as a proactive, efficient, cost-effective extension of traditional behavioral health assets such as the department psychologist and employee assistance program. By providing employees with an informal, readily accessible personal assistance network, the Denver Police Department Peer Support Project continues to serve as a first line of defense against personal concerns that might otherwise not be addressed. The Denver Police Department has benefited from, and is grateful for, the efforts and sacrifices of the officers who came together in 1982 as the original group of Peer Advisors.

Policy

Peer Support Programs shall maximize existing departmental resources by providing employees with additional options and tools for dealing with personal problems.

Peer Support Programs shall be staffed by Peer Advisors operating under the supervision of the Department Psychologist. Peer Advisors are permanent paid department employees who have been specially trained to assist fellow employees by providing services such as information, guidance, advice, referrals, consultation, and liaison with healthcare professionals. Peer Advisors render these services voluntarily in addition to their regular work assignments. At the discretion of their supervisor(s), they may conduct Peer Support activities while on duty provided that this does not interfere with their regular work assignments, violate department policies or procedures, or otherwise disrupt department operations. Peer Advisors do not provide professional services such as diagnosis or treatment of mental disorders, psychological assessment, testing, counseling, or any other activity that might constitute the practice of psychotherapy under the Colorado Revised Statutes or other applicable laws.

Definitions

Client
In this policy, the term "Client" shall refer to any Denver Police Department employee that makes a self-initiated contact, is referred to, or is contacted by a Peer Advisor. Any Client, whether of the classified service or career service, may maintain a mutually consensual peer support relationship with any Peer Advisor of the classified service or career service.

Peer Advisor
A Peer Advisor is a Denver Police Department employee specially selected and trained to provide a first line of assistance and basic crisis intervention to fellow employees. Peer Advisors work in a voluntary capacity to assist employees during times of personal and professional crisis. Peer Advisors are trained to recognize situations and events requiring referral of clients to the Police Psychological Service Unit. Peer Advisors may be peace officers (member of the classified service) and civilians (members of career service). As Peer Advisors interact amongst themselves within the program, rank or position within the department is not a significant consideration.

Police Psychologist / Police Psychological Service Unit
The Police Psychologist will supervise the Peer Support Project of the Denver Police Department and provide voluntary and confidential services to all Denver Police Officers and their families (26.00 of the Operations Manual) and civilian (career service) employees. The Police Psychologist will assist in the selection, training, and retention of Peer Advisors and provide consultation regarding client and other Program matters as needed (116.18 of the Operations Manual).

Family Liaison Officer
Peer Advisors of the classified service (peace officers) selected for additional training and responsibilities in line of duty injuries and death. The Family Liaison Officer's role is as facilitator between the Department and the officer's family (116.19 of the Operations Manual).

Project Director
The Project Director oversees the operational aspects of the Peer Support Programs providing services to Denver Police Officers (established in 1982), career service employees at the Communications Bureau (established in 2002?), and career service employees of the Denver Police Department (established in 2005). The Project Director provides assistance and consultation to the Program Coordinators.

Program Coordinator
The Program Coordinator oversees the operational aspects of his or her specific Program and acts as the liaison between their Program and the Project Director / Police Psychological Services Unit.

Appendix N

Organizational Structure

Chief of Police

Deputy Chief - Administration

Police Psychologist

Project Director

Program Coordinator Denver Police Officers	*Program Coordinator Communications Bureau*	*Program Coordinator Career Service Employees*

Each Program may maintain its individual policy, client statistics, agendas, meetings, continuing education, and client review with the Police Psychological Services Unit provided no conflict exists with this policy.

Project Director Responsibilities

The Project Director is appointed by the Chief of Police (or his designee) to oversee the Peer Support Programs within the Denver Police Department.

Responsibilities include:

- To maintain the integrity of each Program and to constitute a line of accountability with the Chief of Police and Police Psychologist
- To assist in the formulation and administration of Program policies, procedures, guidelines, directives, etc.
- To insure adequate administrative support for the Programs
- To insure adequate funding for the Programs (i.e. training)
- To assist in the solving of any major problems and to consider complaints and grievances related to Peer Advisors and Program functioning
- To maintain records, statistics, and other documentation of Program activities
- To assist Program Coordinators in the selection and training of new Peer Advisors
- To assist Program Coordinators in acquiring continuing education for Peer Advisors
- To promote and market the Peer Support Project throughout the Department
- To assist the Police Psychologist in his or her duties and liaison with the Police Psychological Services Unit

Program Coordinator Responsibilities

- To manage the day-to-day operations of the Program
- To assist in the formulation and administration of Program policies, procedures, guidelines, directives, etc.
- To facilitate Program meetings with Peer Advisors
- To maintain records of Peer Advisor and Program activities
- To assist in the recruitment and training of new Peer Advisors
- To assist in the continuing education of existing Peer Advisors

- To assist the Police Psychologist with his or her duties
- To promote the Peer Support Project within the Department

Eligibility

Any non-probationary police officer (classified service) or civilian (career service) employee with an appropriate disciplinary history is eligible for the position of a Peer Advisor.

Selection and De-Selection

Applications for the position of Peer Advisor will be solicited as individual Program needs dictate. Candidates will be drawn from a list of eligible individuals who have submitted an application (Appendix A) to a specific Program. Candidates will then be required to undergo an evaluation in the form of an interview with a board consisting of:

- The Police Psychologist (or his or her designee)
- The Project Director (or his or her designee)
- The Program Coordinator (or his or her designee)
- Peer Advisors selected by the Program Coordinator

The selection board may consider characteristics and traits such as the applicant's reputation within the department, social skills, ability to empathize, previous education and training, job experience, previous use of a Program, motivation, sincerity, ability to complete training, and adherence to program policy.

Final approval for selection of Peer Advisors rests with the Chief of Police.

The newly selected Peer Advisor will sign a Memo of Understanding / Confidentiality Statement (Appendix B).

The newly selected Peer Advisor will be required to successfully complete all the training requirements of the Program.

Due to the sensitive nature of peer support work, Peer Advisors can be dismissed (De-Selected) at any time at the discretion of the Chief of Police and or in violation of the Memo of Understanding / Confidentiality Statement.

Training

Initial training for the newly selected Peer Advisor currently consists of a 40-hour curriculum that includes instruction concerning mental health, suicide, grief, chemical dependency (and other compulsive behavior), counseling skills, listening skills, issues with families and children, critical incidents, trauma, vicarious trauma, anger management, stress management, and referral techniques.

Meetings and Documentation

Program Coordinators will facilitate regular meetings, with their Peer Advisors, at a frequency approved by the Chief of Police who may provide Special Assignment time. The Police Psychologist (or his or her designee) will attend a portion of the meeting to provide assistance and consultation reference past and on-going contacts with clients. These meetings will also provide opportunities for continuing education.

Program Coordinators will insure Client Contact Sheets (or other methods of capturing data) are completed and submitted on a timely basis. The sheets may indicate the number and type of client contacts, but no information that could identify individual clients will be recorded. The data will be forwarded to the Project Coordinator on a regular basis.

Ethical Issues

The behaviors and actions of a Peer Advisor reflect on the credibility of all three department Programs and the Peer Support Project as a whole. Inappropriate behavior can damage the trust fellow employees place in the Project.

Paramount is the personal integrity of each Peer Advisor and his or her respect for each client's dignity, self-development, and personal welfare.

Peer Advisors will not exercise power over clients or derive personal gain from helping them. It is unethical for a Peer Advisor to accept any gift or remuneration from a client, engage in activities to meet their personal needs at the expense of the client, or to ask for favors or help from clients. A Peer Advisor's sole reward is the satisfaction of helping a troubled employee.

In developing trust with a client, it is beneficial to explain the Peer Advisor's role and describe what services can and cannot be offered. Peer Advisors are primarily caring and attentive listeners, serving as a bridge to helping troubled employees find the professional help they require, and not tasked to solve the clients' problems for them.

Peer Advisors must be knowledgeable with state statutes and department policy involving confidentiality. Peer Advisors must advise clients when confidentiality can and must be breached (such as indications of illegal behavior or an indication a clear and imminent danger exists to the client or others), preferably at the outset of any contact.

Peer Advisors must not enter into a "dual relationship" with clients. These can include situations where the client is a subordinate or supervisor, the client is a subject officer or panel member of a Disciplinary Review Board or similar process involving the Peer Advisor, the client's need for peer support stems from an incident involving the Peer Advisor, and other situations diminishing the Peer Advisor's ability to remain objective. Peer Advisors must strive to be neutral, not partisan or aligned with management or employee organizations. The Peer Support Project relies on the trust and endorsement of both management and employees.

(Appendix A)

Peer Support Project Application

I am applying as (check one):
□ A Denver Police Officer
□ Career Service Employee – Denver Police Department
□ Career Service Employee – Assigned to the Communications Bureau

Name & Badge Number_____

Current Assignment_____

Telephone Numbers:

(Work)_____

(Home)_____

(Cell / Pager)_____

Education / Training in Psychology, Sociology, Counseling, Healthcare, Crisis Intervention, or other areas you feel may assist you in the role of Peer Advisor:

_____

_____

_____

_____

_____

Have you ever utilized Peer Support? If so, what did you think of the experience?

_____

_____

_____

Why do you want to be a Peer Advisor?

_____

_____

_____

_____

What assets would you bring to the Peer Support Project?

What deficits would you bring to the Program?

What is your perception of the role of "Peer Advisor?"

What is your understanding of what the Peer Support Project is trying to accomplish?

As a Peer Advisor, how would you build trust with a fellow employee?

From time to time you may be called to respond to an urgent call for assistance from a fellow employee, another member of the Program, a supervisor,… in the middle of the night or on your day off. Are you willing to do this without compensation?

Please list three Denver Police employees for references:

Is there any other information you would like considered?

Appendix N

Memo of Understanding / Confidentiality Statement

I _____, the undersigned, agree to serve as a volunteer with the Denver Police Peer Support Project and agree to the following commitments:

1. **Attend a mandatory 40-hour training session in Peer Support Techniques.**
2. **Attend Program meetings and continuing education opportunities as necessary per my Program Coordinator.**
3. **Maintain strict confidentiality regarding Program services conducted, including topics discussed and personnel involved, at these meetings and when other Program business is conducted.**
4. **Complete required records of activities (i.e. Contact Sheets).**
5. **Abide by established Project & Program policy, applicable Operations Manual sections, and applicable statutes.**

The undersigned hereby acknowledges his / her responsibility to keep confidential any information obtained during a Peer Support contact(s) as well as all confidential information of the Peer Support Project. The undersigned agrees not to reveal to any person or persons except authorized Peer Support Project personnel any specific information obtained during a Peer Support contact and further agrees not to reveal to any third party any confidential information of the Peer Support Project, except as required by law.

Dated this _____ day of _____ 2013.

_____
Peer Advisor

_____
Program Coordinator

_____

Appendix N

Project Director