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Law Enforcement Mental Health PTSD

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LAW ENFORCEMENT MENTAL HEALTH-PTSD

by

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Abstract

Law enforcement officers respond to and witness some of the most tragic events that happen in our communities. On-the-job stress can have a significant impact on their physical and mental well-being, which can accumulate over the course of a career. Many officers struggle with alcohol abuse, depression, suicidal thoughts, post-traumatic stress disorder and other challenges. It is essential to ensure that officers continue to protect our communities and respond to the needs of people living with mental illness. Law enforcement agencies and communities need to make officer mental wellness a priority from hire to retire. Compared to the general population, law enforcement officers report much higher rates of depression, post-traumatic stress disorder, burnout, and other mental health conditions. Implications for mental health professionals include the need for understanding the profession in addition to the effects of these incidents

Keywords: Post Traumatic Stress Disorder (PTSD), Law Enforcement, critical incident

BACKGROUND

One of the occurrences that happen and are in the minds of our law enforcement across the nation is having to use deadly force against another human being. While this may seem to be "just part of their job" it is not. Officer involved shootings are not a daily occurrence; there are veterans of law enforcement that have never discharged their weapons on another human being. The men and women in law enforcement are trained to protect others as well as what many forget, to also protect themselves. It is their sworn duty to protect and serve. We need to remember that our law enforcement officers need support and assistance, especially after an incident that happens in the blink of an eye. On Tuesday November 5th, 2019 in a small town in Monroe County, Wisconsin with a population of less than 1000 people, what started out as a regular patrol night ended up being an officer involved shooting incident that included city, county and state police departments. While the facts of the case will be modified slightly, the specific Officer will be anonymous in this report. The officer presented to a rural Emergency Department saying he needed to be "cleared" and as instructed by his Supervising Sargent. The registered nurse assigned to the officer knew that there had been an incident within the last hour, however details were very minimal from the officer's perspective. The officer was not physically injured; however, it was clear that he was a under a great deal of stress. When asked if he had discharged his firearm, he said" "I can't say, I was just told to come here." Having worked with law enforcement in the capacity of an registered nurse, the procedure for after an incident like Department of Transportation rules, involved personnel need to submit to urine and blood drug screening. So, knowing and understanding what he was there for narrowed the focus when talking with him, and knowing that he just discharged his service weapon at an incident, the focus for the registered nurse was to keep the officer safe and

in a controlled environment for his emotional health. When there is an incident, supervisors, State Department of Justice designees, other officers as well as the media, come out of nowhere in a rapid fashion. There is no handbook for how an officer is supposed to act or feel or even respond following an incident. It was obvious this officer would need to be given extra time necessary to process the events, specifically needs for emotional support in the immediate time period as well as in the future.

Prior to the officer presenting to the emergency department the only information that the registered nurse was aware of was that this was a" call related to a domestic dispute, and the male suspect had a firearm, and was possibly suicidal. The suspect in this case was brought to the emergency room, where resuscitation efforts continued and then were stopped" secondary" to no life sustaining vital signs for an extended period. The suspect, now deceased, is also considered evidence in the case and his body was transferred to the custody of two State Patrol officers until the Medical Examiner and the Department of Justice released the body for autopsy pending further investigation.

CASE REPORT

One of the three officers involved presents to the Emergency Department at the request of the law enforcement supervisor immediately post incident, as per county policy. The officer denies any previous depression, anxiety or thoughts of suicidal ideation. Presents with a gruff demeanor, and pressured speech due to event. He stated, “ I was told to come here for medical clearance" Physical assessment was completed with no abnormalities, current incident happened within last hour, which started as a domestic violence 911 call, the victim fled home and went to a business across the street, the suspect followed and was in possession of a firearm, law enforcement from multiple agencies responded, patrons in business hid within a bathroom, the suspect shot into the

business and at that time, the suspect was fired upon by law enforcement. Medical aid was given, and the suspect was transported to a local hospital.

Suspect is deceased, officer was not aware until decedent was taken out by Medical examiner “was that the guy, Is he dead?” The nurse responded that yes, he was, in fact, deceased. Officer and RN continued the discussion regarding what could potentially affect him including, insomnia, post-traumatic stress disorder and how our brain functions as a protective device. He was encouraged to talk with family and peers, regarding incident, giving regard to the fact that this still is an ongoing investigation. Total time including Department of Justice investigation requests, with officer was 3 hours. The officer left the emergency department with resources and personal contact information. Safety is the biggest priority and he verbalized that he felt safe and denied suicidal ideation. The registered nurse discussed anxiety and overstimulation on the upcoming few hours with investigation and debriefing per their policy. He verbalized" understanding and" appreciation of the information “and talking to me like a human.” The plan will be to continue to follow up with patient.

ASSESSMENT

Previous illnesses & treatment: The officer denied any chronic conditions, other than normal childhood illness. Immunizations are up to date – verified via Wisconsin Immunization registry.

Surgeries/hospitalizations: None

Head injury (+/- LOC) and workup/imaging: No recent head injuries, concussion in high school related to football, No loss of consciousness.

Medications: No medications other than over the counter ibuprofen, Tylenol and occasional allergy medication.

Alcohol use: Occasional alcohol use, not when working or night/day before being on duty. Reports times of binge drinking, however, denies blackouts, withdrawals or alcohol use that is excessive.

Substance use: (caffeine, nicotine, over-counter/illicit med/drugs)- Caffeine use daily, nicotine use consists of occasional cigarette smoking and tobacco chewing, daily.

Place of birth: Northern Wisconsin hospital

As a child: (family structure, parents' occupations, relationship with parents, siblings, friends, abuse) Family unit includes biological parents, 1 sibling (brother), States that he had no issues growing up, parents active in he and his siblings' lives, including sports. Parents involved in lives, both previously" worked in law enforcement. Denies any abuse physical or emotional. Close to extended family including grandparents, felt supported

As a teen: (friends, relationships, school, activities, sex, trouble, relationship with parents)- I think I was a typical guy" as a teen, continued in sports, average grades, no issues with friendships, did have a girlfriend during high school, denies any abuse during that period of time. Denies trouble at school, or with outside agencies. Enjoys hunting, working on cars, "guy stuff." Denies excess use of alcohol "not gonna lie, we did drink." Denies use of any other substances elicit or otherwise.

As an adult: (work, finances, education, relationships, family, goals for future, trends in functioning) Went to Technical School for law enforcement, lived at home, worked in the County Jail for experience and income while in school, good work history, denies any issues with peers. "I am an easy-going guy for the most part."

Appearance: Clean, appropriate, wearing deputy uniform, removal of duty belt per hospital policy

Behavior: Restless, good eye contact, immediate responses

Speech: Somewhat pressured at beginning of visit, normalized by end of visit

Emotion: Appears anxious, denies anxiety currently

Affect and mood- Slightly blunted, is able express emotions

Perception: Denies hallucinations or delusions.

Thought process: logical, goal directed

Thought content: Future oriented, denies suicidal ideation

Concentration: Able to concentrate on questions and current situation

Memory: Memory intact- recall appropriate

Insight: Good

Judgment: Good- Currently appropriate

Suicide: Denies suicidal and homicidal ideation

Due to the nature of this specific incident, follow up will be started immediately. The safety of the officer is with in normal limits. Symptoms discussed including anxiety, insomnia, coping strategies as well as given contact number within law enforcement with included mental health contacts. The Department of Justice is involved and will investigate as per protocol. Resources for 3 other officers involved are also included. The impact of taking a person's life can and does have a devastating and life altering impact on any officer who is forced into that situation. Also affected peripherally, the officer's family, which can sometimes be overlooked by those outside of the law enforcement community. Critical incidents can leave a profound effect not only on those involved but surrounding individuals, side effects of these traumatic events may surface at home, work and in daily life and can include anger, depression, frustration, grief, insecurity, confusion and disillusionment. There are many things that officers can do for themselves, most importantly, police officers can change the way they think about reaching out for help. By breaking the thoughts of association that asking for help is being defective or weak is dysfunctional

and not rational. It makes little sense for police officers to physically survive a career in law enforcement only to be psychologically undone by the stressors of a critical incident or even the job itself.

Responses following a critical incident

Heightened sense of danger, anger, frustration and blaming. Isolation, withdrawal, sleep difficulties, intrusive thoughts, emotional numbing, depression and feelings of guilt. Also, it is possible that there can be no depression, having feelings of done well, sexual or appetite changes, second guessing and endless rethinking of the incident. Interpersonal difficulties, increased family discord, increased alcohol or drug use grief and mourning.

Axis I: Psychiatric disorder: At risk for post-traumatic stress disorder, depression, anxiety, insomnia, as well as any disorder in the following categories: adjustment disorders, anxiety disorders, dissociative disorders., mood disorders, sleep disorders., substance-related disorders.

Axis II: Personality: Currently none

Axis III: Medical conditions: Currently none

Axis IV: Social factors: Currently none At risk for: Problems with primary support group, problems related to interaction with the legal system/crime, occupational problems, problems related to the social environment.

Investigations

There are no medical investigations that need to be done currently other than requested urine drug screen" and blood draw requested per Department of Justice protocol that was witnessed and sealed. This is a healthy male and the current responsibility to his is support and safety

Treatment:

Psychological**:** A formal debriefing is conducted by a mental health professional and veteran peers (PEAP-Police Employment Assistance Program) who are thoroughly trained in critical incident stress. Intervention should begin as soon after the trauma as possible to provide officers a way of understanding the experience in the most constructive way and before they solidify their thinking about the event in maladaptive and self-critical ways. Intervention should be centralized to support the most efficient and effective use of time and resources. "post shooting trauma" begins after approximately 48 hours and can last from six to eight weeks. A one week to six weeks follow-up, initiated by the officers can allow them to express their feelings about departmental management.

LITERATURE REVIEW

Post-traumatic stress disorder prevention within law enforcement appears to be one of the ways to help prior to having a critical incident. Prevention policies and research have been started for use within the military and is also being used in the civilian sector. There are minimal studies currently about law enforcement specifically. There are clear challenges regarding the treatment of" either prior to any event or after a significant event with this population. These barriers can include a fear of appearing weak, a fear of a breach of confidentiality and a fear that seeking help will harm their careers (Charoen, 1999). Whether police officers actively seek help and support for themselves or not, there is clearly a moral, ethical and legal duty to ensure that an officers' health and well-being is looked after, as police officers undertake some of the most challenging and unpleasant tasks on behalf of the rest of society.

Over approximately the last fifteen years, early psychological interventions, such as psychological 'debriefing', have been increasingly used following psychological trauma. Whilst

this intervention has become popular and its use has spread to several settings, empirical evidence for its efficacy is noticeably lacking. The risk of developing post-traumatic stress disorder after exposure to a traumatic event depends on many factors, including sex, age, ethnicity, sexual orientation, education attainment, intelligence quotient, annual income, childhood behavioral problems, prior exposure to a traumatic event, and a family history of psychologic disorders. According to (Ross, 2013), known risk factors for PTSD in military populations include experiencing combat, being wounded or injured, witnessing death, serving on graves registration duty or handling remains, being taken captive or tortured, experiencing unpredictable and uncontrollable stressful exposure, and experiencing sexual harassment or assault. Severe combat stressors include an increased number of unpredictable insurgent attacks in the form of suicide and car bombs, improvised explosive devices, sniper fire, and rocket-propelled grenades, which all increase the risk of being wounded or killed and thereby exacerbate the psychologic stress. Higher rates of PTSD and depression are associated with longer deployments, multiple deployments, and greater time away from base camp. Conversely, protective factors for PTSD include good leadership, unit support, and training, all of which may help promote positive mental health and well-being during deployment and thus reduce the risk for PTSD (National Academy of Sciences, 2015).

Prevention is broadly defined as measures taken to avoid the occurrence of disease or "interventions that are applied before the onset of a clinically diagnosable disorder with the aim of reducing the number of new cases of that disorder" (Munoz et al., 1996, as cited by Boyce et al., 2007). The term can also be applied to an intervention aimed at limiting the disorder's progression, relapse, or associated disability. Prevention of PTSD in active-duty personnel is provided via programs aimed at preparing service members for combat and other deployment-

related stressors. Some programs focus on reducing the risk of exposure to traumatic events (such as interventions aimed at reducing the risk of military sexual trauma) and on training service members to respond effectively to such events if they occur (Bryant, 2003).

Studies suggest that individuals experience a broad range of traumatic events throughout their lives, and that the frequency of these events may vary by the group studied, for example, civilian versus non-civilian. Most of the research has focused on assessing the burden of trauma in different populations. Studies among groups at risk of occupational exposure to trauma, such as police officers, firefighters, and military service members, have shown high rates of trauma exposure. Stress hormones released during exposure to a traumatic event have also been identified in the development of Post-traumatic stress disorder. Some studies have shown that elevated levels of cortisol and adrenaline can disrupt the normal formation of memories, while others have found that stress hormones enhance memory consolidation (Bryant, 2003) (Pitman, 1989).

Psychological debriefing was a widely used method in the 1980s–1990s which aimed at preventing long-term post-traumatic symptoms by promoting quick emotional processing of traumatic events shortly after trauma exposure. The method typically involved a single session within hours or a few days after trauma exposure, either in a group or individual, and included general education about trauma exposure and its effect, sharing and validation of individuals' experiences, and preparation for future encounters. However, well-conducted studies showed no evidence of beneficial effects and even suggested that debriefing may have a negative effect on recovery (Rose S, 2002). After a negative Cochrane review was first published in 1997, most treatment guidelines have been updated to recommend against providing single session psychological debriefing on a routine basis for adults after trauma (Forbes D, 2007).

Cognitive theories of post-traumatic stress disorder are based on the concept that information associated with a traumatic event is inconsistent with the information contained in an individual's core cognitive schema. An individual exposed to a traumatic event tries to make sense of the experience but has difficulty fully integrating it into his/her existing schema. Over time, this disintegration manifests itself in the symptoms and behaviors classified as post-traumatic stress disorder. Maladaptive beliefs related to the traumatic event have also been identified as a risk factor for the development of PTSD (Bryant, 2003).

According to (Cornelius & Kenyon-Jump, 2007) cognitive behavioral therapy is currently the mainstay of early prevention of post-traumatic stress disorder. Early cognitive behavioral therapy is strongly dependent on the type of traumatic event. Cognitive behavioral therapy was most effective for sexual assault victims, had a marginal effect among accident victims, and was not effective for victims of physical assault. Additionally, cognitive behavioral therapy the traumatic event and its initial effect was conserved for 3 years. Cognitive behavioral therapy is therefore a 'must try' in symptomatic trauma survivors, for many of whom it may shorten symptom duration by months and years.

Psychological interventions including" trauma-focused cognitive behavioral therapy, cognitive restructuring and cognitive processing therapy, Exposure-based therapies, coping skills therapy (including stress inoculation therapy), psychological first aid, psychoeducation, normalization and" psychological debriefing (Charoen, 1999).

Various pharmacological agents have been examined in the prevention of post-traumatic symptoms. A Cochrane review in 2014 concluded that in general, there is moderate quality evidence for the efficacy of hydrocortisone, and no evidence for propranolol, escitalopram,

temazepam, and gabapentin (Delahanty DL, 2013). This field is rapidly developing as the neurobiological process underlying start to be clarified by more studies.

Hydrocortisone has been shown to be effective especially in patients who have never been treated for psychiatric disorders (Delahanty DL, 2013) (Cornelius & Kenyon-Jump, 2007). Benzodiazepines are gamma-amino butyric acid agonists and thereby enhance inhibitory transmission in many areas of the brain. They are used as tranquilizers and sleep inducers—also interfering with long-term potentiation and therefore with learning and, in acute administration, with memory acquisition. They were positioned as capable of reducing excessive trauma-related learning, but then mostly tried for possible preventive effects on post-traumatic stress disorder during the aftermath of traumatic events despite having no known effect on retrograde recall (Forbes D, 2007).

Animal studies suggest that morphine can produce retrograde amnesia for contextual conditioned fear, through decreasing cyclic adenosine monophosphate or activating N-methyl-D-aspartate receptors in the hippocampus. Observational studies of hospital patients also suggested a possible beneficial effect of morphine administration within 48 h after trauma exposure to survivors who experience pain, reducing the likelihood of a PTSD outcome (Mouthaan J, 2015).

Propranolol is a beta-adrenergic antagonist that crosses the blood-brain barrier and, therefore, capable of reducing the central nervous system adrenergic drive associated with defensive threat responses. Experimental studies of propranolol in healthy subjects have shown that its administration prior to exposure to potentially traumatic narratives reduced the recollection of stressful elements of the narrative without affecting the general recall (Delahanty DL, 2013).

Oxytocin is involved in emotion stress regulation, social engagement, and attachment. Olff et al. (2010) have suggested that oxytocin may buffer the development of PTSD by reducing fear

responses and increasing social functioning. The group is currently conducting a randomized control trial to examine the efficacy of intranasal oxytocin administration in preventing PTSD.

Trauma risk management" is a peer support system that aims to risk-assess, provide support and educate staff after a traumatic event. It consists of a risk assessment interview, three days post event, to assess the trauma and identify those in immediate need of specialist help (Charoen, 1999). Post-traumatic stress disorder, despite its critical importance, is under-researched and inappropriately explored.

Conclusion

Post-traumatic stress disorder, despite its critical importance, is under-researched and inappropriately explored. Law enforcement officers respond to and witness some of the most tragic events that happen in our communities. On-the-job stress can have a significant impact on their physical and mental well-being, which can accumulate over the course of a career. Many officers struggle with alcohol abuse, depression, suicidal thoughts, posttraumatic stress disorder and other challenges. It is essential to ensure that officers can continue to protect our communities and respond to the needs of people living with mental illness. Law enforcement agencies and communities need to make officer mental wellness a priority from hire to retire. Compared to the general population, law enforcement report much higher rates of depression, post-traumatic stress disorder, burnout, and other anxiety related mental health conditions. Implications for mental health professionals include the need for understanding the profession in addition to the effects of these incidents. Even daily law enforcement activities that can potentially occur regularly and can also be ongoing exposure to confrontation, verbal and physical aggression and the potential for harm. This working environment alone can increase the needs for mental health intervention and certainly increases the chance for post-traumatic stress disorder. With specific regard to critical

incident management, law enforcement may become emotionally overtaxed which can change the reactions of a person from just sheer exhaustion to an unrelenting cascade of mental health symptoms. Having a plan in place by each agency and having support available has been deemed one of the most effective ways to possibly prevent post-traumatic stress disorder progression, or at least identify where there is more help that could be necessary for specific individuals. Ideally the change in culture with discussing mental health and the potential implications of high stress/ profile professions there would be less stigma attached to law enforcement that it “is just part of the job" and that there is no shame in getting assistance. Since the incident on Sept 11 there has been more discussion and positive movement forward for responding agencies to any critical incident. The conversation was started, and we are moving in a forward direction with assistance to all, prior to, during and after any incident that requires time to take care of the ones that protect us.

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