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PTSD – Returning To Duty After Critical Incident Or Military Combat Deployment- Policy For Reintegration

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ABSTRACT

Post-Traumatic Stress Disorder (PTSD) is becoming more recognized among law enforcement officers around the world. Years ago, officers would overlook the symptoms associated with PTSD and would try to work through it because of the stigma associated with the illness. Today, there are thousands of police officers around the nation with previous military service while others are currently serving in the National Guard and Reserves. Among these peace officers who have served in combat and regular officers without military experience who have encountered a critical incident are all too often undiagnosed with PTSD.

There needs to be a standardized policy for law enforcement officers who have been involved in a critical incident, officer involved shooting and returning combat veterans which requires a formula for returning to work. The policy should be progressive in nature and should require an officer returning to duty after a critical incident to slowly integrate back into the routine duties they were performing at the time of the incident. The policy should mandate that an officer trained in peer support counselling will be partnered with that officer until such time the officer is cleared to return to normal duty activities.

An officer should be educated about PTSD as well as the officer's family. A family member can monitor an officer for symptoms of PTSD which he/she might not see or have denial about such symptoms. Having the officer partner with a peer support officer for integration purposes allows the peer support officer to not only educate the officer, but his family as well.

CONTENTS

INTRODUCTION

Post-Traumatic Stress Disorder (PTSD) is a frequently overlooked condition among law enforcement officers around the world, with police officers often trying to work through it on their own because of the stigma associated with the illness (Bell, & Eski, 2015). With 22% of police officers being veterans, there are thousands of police officers around the nation with previous military service while others are still serving in the National Guard (Lewis & Pathak, 2014). Among officers who have served in combat and officers without military experience who have encountered a critical incident, PTSD may be unrecognized.

Due to the stigma associated with PTSD and the possibility of getting treated with medication, officers tend to refuse the help that they need (Haugen, McCrillis, Smid, & Nijdam, 2017). Officers need to be educated about PTSD and how to detect signs and symptoms of the condition. An officer usually struggles with PTSD symptoms without anyone in the department realizing it. Family, on the other hand, may see the deterioration of the officer's mental health or recognize PTSD symptoms and not inform the department of these behavioral changes (Waters, & Ussery, 2007). Without getting assistance and treatment, this can further lead to other conditions like alcohol abuse, anxiety, depression and suicidal ideations (Pietrzak, Schechter, Bromet, Katz, Reissman, Ozbay, et al., 2002). According to the National Alliance for Mental Illness (NAMI), about 1 in 4 police officers have suicidal thoughts at some point in their life (NAMI, 2019). More police die by suicide than in the line of duty with an estimated 140 law enforcement suicides in 2017 (NAMI, 2019). Their suicide rate is four times higher than the rate for firefighters and almost four times the national average (NAMI, 2019).

Compared to the general population, law enforcement officers report much higher rates of depression, PTSD, burnout, and other anxiety-related mental health conditions (NAMI, 2019). The suicide rate in law enforcement is high but proper training and informed policies can make a difference. Having peer support assigned to the officer's family increases the chances of the officer or family member talking to the peer support officer because trust has been established in this special relationship (Greden, Valenstein, Spinner, Blow, Gorman, Dalack, et al., 2010).

There should be policy-based practice across the board for law enforcement officers who have been involved in a critical incident or shooting which requires a program for returning to work. This policy should be progressive in nature and have the goal of getting an officer returning from a critical incident slowly integrated back into routine duties they were performing at the time of the incident. This policy should mandate that an officer trained in peer support counselling be partnered with the officer returning from critical incident until such time the latter is cleared for normal duty.

A psychological evaluation is not automatic; however, it should be left up to the administrator or policy maker to determine the necessity of such evaluation (Chapin, Brannen, Singer, Walker, 2008). It should be department policy that an officer attend a peer support group or necessary psychological counselling for a predetermined amount of visits before returning to duty. Several things can be accomplished by the services provided by peer support groups or a licensed psychologist. An officer who has been involved with a critical incident would be made aware of the symptoms that are associated with PTSD and the available resources in the event the symptoms worsen or persist for a period of time.

This policy should include education programs so that police officers and their families would be informed about PTSD. A family member can monitor an officer for PTSD symptoms which an officer might not realize and/or deny. Having the officer partner with a peer support officer allows the peer support to educate the officer and his/her family. The overall well-being of the returning officer is the primary priority and goal in providing peer support from within the agency. By implementing this policy we are protecting not only the officer but also his family, the department and the community.

Police departments should create and implement this policy for gradual reintegration of officers with PTSD after critical incidents or combat in the Armed Services. Law enforcement officers have been independently dealing with post-critical incidents alone, with little assistance from their respective departments (Morash, Haarr, & Kwak, 2006). An empirical review of studies on first responders in 2012 reports worldwide prevalence of PTSD at ten percent in rescue workers in general (Faust, & Ven, 2014). The prevalence of PTSD among police officers ranges anywhere from seven to 19 percent, yet not all departments have a policy in effect for any type of mental health related counselling (Faust, & Ven, 2014). Only one out of five large departments accommodate a stress reduction program that may or may not have a psychologist to evaluate officers after a critical incident (Bettinger, 1984). Furthermore, after the officer is initially cleared of any wrongdoing or policy violations, he/she is then allowed to return to normal duty. There are military veterans returning from active duty overseas who return to their duty stations after combat and are immediately put back

onto regular duty without evaluation (Kaplan, 2008). This is where the problem starts for the officer who might soon face challenges and is at risk of developing PTSD.

The National Institute for Mental Health (NIMH) defines PTSD as an anxiety disorder that some may develop after seeing or living through a dangerous event (NIMH, 2019). Fear and anxiety are expected immediately after a critical incident and resolve spontaneously (NIMH, 2019). If the symptoms last longer than a week or persist months later, then this is considered PTSD and treatment may be necessary (NIMH, 2019). PTSD has different symptoms and may manifest in people in different ways. Officers often have “flashbacks” which means they may be reliving the event. These flashbacks often occur during sleep and the person feels the same fear and horror as they did when they experienced the event. Other times it might be a sight or a sound that triggers the flashback (NIMH, 2019). Those who suffer from PTSD will frequently avoid situations that remind them of the traumatic event (NIMH, 2019). They can often experience feelings of numbness which makes it hard for them to express their feelings. This numbness can be associated with an absence of emotions or feelings towards other people and may cause them to avoid relationships. Activities and interests, which one may have used to enjoy, may be lost (NIMH, 2019).

According to the NIMH (2019), hyperarousal is one of the last and sometimes the most frequent symptom one suffers from PTSD. Increased arousal and reactivity manifest, such as being jittery, on alert, and always on the lookout for danger. It can make a person become suddenly irritable or angry, have difficulty sleeping and/or have problems with concentration (NIMH, 2019). Often those experiencing these symptoms fear for their safety, always feel on guard and get startled easily (NIMH, 2019).

Peace officers are a very prideful people and sometimes feel that asking for help is seen as a sign of weakness (Bell, & Eski, 2015). An officer might also fear if he/she seeks professional help it will be the end of their career (Bell, & Eski, 2015). Failure to seek help voluntarily is the first mistake officers make after a critical incident. Shortly after a critical incident, symptoms of PTSD could start to surface and before too long the officer has a whole new onset of problems (Gerson, 1989). Officers sometimes become very irritable and confused as to what is happening to them and refuse to ask for help (Amaranto, Steinberg, Castellano, & Mitchell, 2003). The last thing an officer wants is to have others lose faith in his/her abilities to carry out their duties. It is standard procedure within most departments to have their service weapon taken from them after the incident and be given three days off on paid administration leave until the case has been cleared through the department. Once they have taken the service weapon from the officer, he/she already feels stripped of his/her dignity. The Texas Department of Public Safety supervisors often carry an extra pistol in their vehicle to replace the service weapon of any trooper involved in a shooting while on duty (Texas Department of Public Safety, 2019). If a spare weapon is not readily available, the supervisor could give their weapon to the trooper to make sure he/she is armed. Having the weapon replaced immediately gives the officer a sense of psychological support from his/her agency (Shane, 2010).

There are no set standards or policies within the State of Texas for the steps to take after a critical incident, officer-involved shooting or a combat veteran returning to work from active duty. Many have suffered because of the lack of interest departments have for slowly integrating an officer into normal duty after any critical incident. This

lack of consideration from the officer's department affects many people. If the officer has a wife and children at home, all parties might suffer from the officer's inability to cope with the trauma if left untreated.

Police departments need to develop policy for reintegration back to normal duty. Guidelines need to be set forth in policy as to what type of counselling, including psychological counselling, the department requires before being cleared for duty. Without this being established as a department policy, the department cannot make an officer seek treatment. With the stigma associated with PTSD and career concerns, officers will more likely refuse evaluation and counselling, unless policy has been established. Without departmental policy, there will continue to be an overwhelming number of officers patrolling within our communities who might never be the same. Departments owe it to the officers and their families to make sure they receive the help they deserve.

One of the greatest reasons a department may want to consider a reintegration policy which mandates counselling is to reduce the risk of a lawsuit (Aveni, 2003). The lack of oversight and responsibility falls on the department in the event the officer is responsible for a citizen or fellow officer getting injured or killed. It is also important to realize the difference between a critical incident involving an officer and dealing with an officer who has just returned from a deployment in the Armed Services. Reintegration has been formally defined as "the process of transitioning back into personal and organizational roles and society" after deployment (Currie, Day, & Kelloway, 2011, p. 38). The officer who has just returned from active duty in a combat unit may need more time for integrating back into the workforce. It is not unusual for a returning veteran

officer to take personal time off after returning from combat for several reasons. It takes time for a combat veteran to adjust back into the civilian world and three to six months might be exactly what is needed for the transition. One must realize the emotional and psychological trauma the veteran might have been exposed to during combat. Once they have returned from active duty, they need time to decompress and fall back into their previous lives.

POSITION

The first position taken is to have a policy clearly defining the procedures for gradual integration and return to duty after a critical incident or from an active duty deployment in the armed services. An officer returning to duty after a serious incident or officer involved shooting will be having many difficulties (Fox, Desai, Britten, Lucas, Luneau, & Rosenthal, 2012). Usually within the first 24 to 72 hours after the critical incident the officer has received a debriefing from the department (International Association of Chiefs of Police, 2016). The debriefing usually occurs after the officer has given his statement of the incident (International Association of Chiefs of Police, 2016). By this time, the officer has probably discussed the incident with numerous people and relived the incident anywhere from 10 to 12 times. The debriefing is critical to the officer's overall mental health and sets the stage for recovery; however, it should be conducted by certified and/or trained critical incident management personnel. This type of counselling has been proven to be beneficial to the officer's recovery and ultimately his/her overall mental state, speeding up the time it takes to return to normal duty and/or being cleared by a mental health professional (Carlan, & Nored, 2008).

Clearly, there is a difference in the critical incidents between a law enforcement officer and a soldier who has returned from active duty in the armed services. Statistics show that most departmental officer involved shootings occur anywhere from seven to 21 feet (Aveni, 2003). The shootings occur spontaneously without any premeditated notion of having a violent encounter with a suspect (Aveni, 2003). Those who have left their respective agencies and deployed to combat zones overseas generally have different types of critical incident encounters. A veteran combat officer may have returned from a 12 to 18-month deployment in Iraq or Afghanistan where they have experienced multiple encounters with enemy combatants in which the loss of lives had occurred. Nevertheless, after the veteran has returned to his respective agency it is the responsibility of that agency to make sure the veteran is capable of returning to police duty.

Department policy should be established that requires some type of follow-up counselling for a returning officer before resuming his/her duties. Procedures should be established by the police department administrator requiring gradual integration to previous duty assignments. During the integration process, the officer should be attending a peer group counselling session weekly or bi-weekly to monitor their well-being and mental status. It is also recommended at this stage to have the spouse of the officer attend a peer group counselling session or debriefing by the department's critical incident management personnel. Other than the peers of the officer involved, the spouse or family members of the officer are the only ones who really know how the officer might be coping with the incident. Early detection of mental health symptoms is critical to the recovery of the officer (Carlan, & Nored, 2008).

The police officer should be provided the opportunity to slowly resume his/her duties with a fellow officer who can evaluate his/her performance (Morris, Morgan, Gilmartin, 2001). As the department policy, it is less likely that the returning officer will feel that he/she is being singled out and scrutinized. Immediately after an incident, an officer has already been stripped of his/her badge and gun until the incident has been cleared through the department. Feelings of isolation can occur at this time where the officer may feel that the department has turned its back on him/her or has lost trust in his/her abilities (Chapin, et al., 2008).

It may seem to the returning officer that he/she is being micromanaged at this point; however, the dual patrol method upon return to duty is for the benefit of the officer. An officer suffering from PTSD or emotional, mental and physical stress from exposure to a critical incident may have unpredictable reactions to similar situations that trigger abnormal responses during routine patrol (Amaranto, Steinberg, Castellano, & Mitchell, 2003). Sometimes the returning officer may not realize how he/she has been affected by the critical incident until placed in similar circumstances. It is recommended that an additional officer be present to provide reassurance and support to the returning officer (Morris, Morgan, Gilmartin, 2001). It is important to understand that every officer and every situation is unique. During this time, the returning officer may experience symptoms that had been discussed during the counselling sessions and peer support groups.

Without a written policy for mandated counselling, the officers may not seek out treatment voluntarily (Haugen, et al., 2017). Sometimes getting an officer into counselling is the hardest part of the process. Once they have committed to attend

counselling, they will at least know what battle they are fighting. It is not productive for officers to feel scrutinized by being placed in a group counselling session. Besides providing counselling resources, officers need to be informed so they can recognize when symptoms set in or escalate, thus increasing the probability of the officer voluntarily seeking assistance.

It is important that returning combat veterans are not treated the same as officers involved in a critical incident when implementing the return to duty policy. Unlike the traditional patrol officer, the returning combat veteran has been deployed to a combat zone where everyone has been considered to be the enemy. The combat veteran probably has had multiple highly traumatic gun battles where he/she has seen loss of life and severely injured personnel numerous times. Prolonged trauma may create more numbness in that officer to critical incidents and require a different treatment process.

Reintegration back into civilian life for the department starts well before the officer returns to the states from combat (Bureau of Justice Assistance, 2010). The process begins before deployment and will last until the officer returns to duty. The department should assure the officer, his/her spouse and family that they are there to support them with whatever problem that may arise during his absence. This support usually helps the officer feel more secure during the deployment that his/her fellow officers are back home making sure his/her family's needs are met. There are opportunities available currently to provide the spouse and family with post deployment counselling in advance of the return of the officer (Bureau of Justice Assistance, 2010). The same counselling is provided by several veteran programs and military bases.

After all, the officer will be returning to work full time for the agency, and it benefits the agency to support the returning veteran in any way possible. The spouse or family of a combat veteran can be a critical link between the department and the officer when it comes to the officer's mental health issues, if any. The trust between the department and the family can build a bridge in the relationship where the family may feel bonded with the agency personnel. They are usually more willing at this point to contact the department when they observe any major changes in the behavior of the officer.

Once the veteran returns from active duty there needs to be a welcoming party from the department which gives reassurance to the officer that the department is really there for a support system. The veteran will need time to decompress from combat and to make the transition from military to civilian life. According to a report from the International Association of Chiefs of Police (IACP), a period of three to six months may be the sufficient time a returning officer needs for the transition (International Association of Chiefs of Police, 2016). During this time, the veteran has had time to seek help from peer support groups and therapy if so desired. Upon returning to duty, the same concept of using a dual officer reintegration program is beneficial. There are several things for the combat veteran that differ from the traditional officer who has suffered from an isolated critical incident. The veteran needs to be placed in specific situations where his/her reaction to the public and certain surroundings can be observed. The combat veteran will possibly be experiencing a completely different cluster of PTSD symptoms than a non-combat officer.

The second position is that mandated counselling has proven to be effective (Carlan, & Nored, 2008). It should be understood that PTSD will not go away untreated

and, in some cases, it will get progressively worse. Fewer symptoms of PTSD were shown when an officer had a good social support team providing the officer an opportunity to discuss the critical incident and emotional impact with others in the workplace (Carlan, & Nored, 2008). Mandated counselling can consist of a licensed psychologist employed or retained by the department, a peer support group, as well as a critical incident management team member who has received training to deal with post critical incidents. Confidentiality is of the utmost importance when placing officers in counselling after a critical incident. Officers today fear the stigma associated with getting help, and more often than not, it is the reason for refusing any counselling. Expanding methods of access also supports the recommendation to increase efforts to fight the stigma associated with accessing psychological and behavioral support (Haugen, et al, 2017). Research has consistently identified stigma as a major barrier to seeking help or attempting to access care (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004).

According to the IACP, an officer who seeks or is provided counselling right after a critical incident is more likely to have less serious conditions than those who do not seek treatment or refuse treatment (International Association of Chiefs of Police, 2016). This is where awareness comes into play by all departments implementing policy to require an officer to get assistance soon after a major critical incident. It has been documented that officers who talk about the incident with others have less severe conditions than those who do not (Bryant, Friedman, 2001; Carlan, & Nored, 2008). There are peer support groups at many agencies that provide counselling and support to the officer and their families. The officer's spouse can receive some type of

awareness training and support from peer groups as well. Many departments now have ties to or currently have staff that are trained in crisis intervention techniques. These groups are specially trained to make themselves available to the officers post critical incident. They encourage the officers to talk about the incident and to share their emotions as well as their thoughts.

Without the resources and the work of the crisis intervention teams, the officers would not have the opportunity to talk about the traumatic incident. It has been documented that without the support of the department and the opportunity to talk about the trauma, the returning officer could sometimes begin a downward spiral of destruction (Fox, Desai, et al, 2012). Many officers do not suffer any symptoms after a critical incident; however, there are those who do need immediate intervention. One must realize there is much more at stake for neglecting the mental health of an officer than the officer alone. Behind every badge is sometimes a spouse, children, parents and siblings. Neglecting to ensure the officer has received the necessary counselling may destroy others' lives. Statistics show that after an officer has been diagnosed with PTSD, there are multiple symptoms that could possibly accompany the after effects of a critical incident. Withdrawal and feelings of numbness are usually the symptoms that create the separation effect of an officer and his family, sometimes leading to excessive drinking and drug use (Stewart, 1998). The officers find a way to self-medicate in a manner that eventually leads to addiction. There is a very high divorce rate among law enforcement officers and an addiction creates hardships on a marriage as well as strained relationships with children and family members (Stewart, 1998).

The third position point is by creating policy for gradual integration after a critical incident will reduce department liability. An agency is ultimately responsible for the actions of its employees. Precarious liability falls back onto the agency administrator in the event of a civil lawsuit. If an officer's actions were outside the normal scope of his/her duties as a peace officer and he/she was found to be unfit for duty, the situation will negatively impact the agency administrator. It is the responsibility of the agency administrator to make sure policy is in effect that will not only protect the department, but the well-being of an officer who plans on returning to duty shortly after a critical incident.

COUNTER POSITION

One position that might be brought up is the fact that Federal law requires an agency to rehire veterans within five years of employment after leaving an agency to deploy for active duty in the armed services. Uniformed Services Employment and Reemployment Rights Act (USERRA) provides employment rights to military service members (Steinman, 2007). The USERRA law, enacted in 1994, provides provisions for military personnel to be able to get their jobs back after an active duty deployment up to five years. USERRA laws provide rights to returning military personnel that make it mandatory for employers to rehire those who have left active duty military status within two weeks of the employee's application for reemployment (Steinman, 2007). Not only does this law require employers to reassign other employees, it also requires them to terminate other employees if necessary in order to create a job opening for the returning service worker. USERRA regulations state that not only do the employees get to return to their previous job, they are required to be placed in a position they would have held in

the event of continued employment. USERRA regulations require employers to return to the pay, benefits, seniority and other job attributes the employee would have held if there had been no military employment or deployment (Steinman, 2007).

USERRA regulations state that employers must reemploy a veteran worker after a period of duty with the armed services or active duty for combat related deployments. However, there is nothing in the federal guidelines preventing agencies from performing fit for duty evaluations on the returning employees. Once the returning veteran has returned to duty after a military deployment and it has been established that the officer may have been affected by combat-related illnesses, other means can be taken to assure the officer is capable of performing the duties as assigned. Therefore, it is very important for agencies to have established policies outlining these types of scenarios. A department that has established clear guidelines in their policies for returning to work after combat or critical incidents reduces the liability associated with termination or reassignment. All employees or veterans should be treated alike when being screened for symptoms after being subjected to a critical incident. It will be at the discretion of the chief administrator if the policy allows for reassignment outside of the regular scope of employment (Chapin, et al., 2008). It may be common for officers who have returned to duty from a combat deployment to request light duty or additional training before returning to full duty (Bureau of Justice Assistance, 2010). Under the USERRA regulations, the employer shall fulfill the requirement of rehiring the employee after returning from a deployment.

Another counterpoint one might assume is that officers who have been treated by a mental health professional and have been placed on medication are unfit for duty.

The assumption that an officer is unfit for duty because of the medications he/she is taking is untrue. Police officers may be prescribed antidepressants known as selective serotonin reuptake inhibitors (SSRI) like Prozac, Paxil, and Zoloft (Becker, Meyer, Price, Graham, Arsena, Armstrong, & Ramon, 2009). There are a lot of police officers taking medications for multiple different reasons and the most common reason is treatment for symptoms associated with PTSD.

One of the most common reasons that officers do not want to take medication is the stigma involved with psychiatric medications (Becker, Meyer, Price, et al, 2009). Officers do not want to be associated with taking medication. For many years, officers have avoided the treatment they need to "save face" with their colleagues feeling that the medication is a sign of weakness. The truth is psychiatric medications are like medications for physical illnesses. SSRI's treat symptoms that cause discomfort and problems for the person. Just like a diabetic patient depends on insulin for survival, those suffering from PTSD need medication to treat their symptoms like any other illness. Fay (n.d.) quotes an officer from San Francisco PD who stated, "Misery is optional." Medications are not the "cure all" or a quick fix but they can significantly improve the quality of life of an officer suffering from symptoms of PTSD (Fay, n.d.).

Current practice guidelines for treatment of PTSD include taking medication to treat the symptoms of PTSD (Rosen, Chow, Finney, Greenbaum, Moos, Sheikh, Yesavage, 2004). In fact, taking medication to prevent the symptoms of PTSD is beneficial to an officer (Bryant, Friedman, 2001). An officer suffering from depression and other symptoms of PTSD may have a slower reaction time than an officer without any symptoms; however, the reaction time on antidepressant medication is minimal

compared to the impairment of cognition of an officer suffering from the same symptoms without medication (Fox, Desai, et al, 2012).

An officer who suffers from symptoms of PTSD and refuses treatment is more of a danger to himself/herself and his/her fellow officers than someone taking medication. An officer with untreated PTSD symptoms will often be unable to perceive danger, process the information and decide how to react in the optimal amount of time (Fox, Desai, et al, 2012). Untreated PTSD symptoms could result in officers who are often more focused inward instead of the external threat surrounding him/her (Fox, Desai, et al, 2012). An officer taking medication to treat symptoms of PTSD and depression will be far more effective if their treatment plan also includes psychotherapy and/or a self-administered program of positive self-talk.

RECOMMENDATION

Police departments across the nation should consider implementing policy that requires a systematic reintegration of officers returning to duty after a critical incident or military combat deployment. Too often, officers are cleared of any wrongdoing after a critical incident or officer-involved shooting and immediately return to normal duty. There are many things to consider after an officer has been involved in a shooting with the main concern being the mental health and stability of such officer. Sending an officer back onto the streets shortly after a critical incident could be detrimental not only to the officer but to the department and civilians as well.

A department administrator is liable for the actions of his/her officers and should take all precautionary measures available to provide services to an officer before returning an officer to duty after a critical incident. It is not necessary in all cases to

make an officer complete a psychological evaluation; however, it should be a policy-based practice to provide the officer with a psychological counsellor of the department's choice or the preference of a private psychological counsellor of the officer's liking. Without a reintegration policy in effect, an officer may refuse to seek treatment.

Administrators of larger departments have their own mental health staff and many agencies have an active peer support group within their department. Peer support officers should be comprised of officers who have experienced a critical incident and have been trained to deal with different types of scenarios and crisis intervention techniques. Assigning an officer who is a member of a peer support group to the returning officer is very important to the overall recovery of the officer's mental health challenges. A peer support member can discuss the potential symptoms involved after a critical incident or officer-involved shooting. It is very important for an officer to be aware of the symptoms associated with PTSD and to recognize these in oneself when the symptoms start surfacing. A peer support officer can educate not only the returning officer, but the officer's family as well.

Once an officer has completed the required mental health counselling or required number of peer support group sessions it is time to integrate the officer into his/her previously held position. An officer trained to recognize symptoms of PTSD shall be assigned to partner with the affected officer for a predesignated time. The support officer is only there to provide support to that officer and to evaluate his/her responses to certain incidents and contact with civilians during calls. The support officer is to document any concerns or potential weaknesses noticed and discuss these with the returning officer. In the event there are certain safety issues that an administrator would

be concerned with, it is the responsibility of the support officer to report these deficiencies to administration. Planned department responses may include requiring additional training, recommending more additional mental health evaluations and/or counselling. In a worst-case scenario, an officer is required to perform a fit-for-duty assessment to see if it is safe for the officer to return to work. One thing guaranteed, by not implementing policy pertaining to this type of situation is detrimental to the officer, his family, the agency and the civilians in that jurisdiction.

Officers who have been involved in a critical incident or officer-involved shooting should receive counselling and support from their agency. Education on PTSD and the symptoms involved should be discussed at length. Reassurances to reduce or eliminate the stigma associated with getting assistance should be given to the officer going to counselling or taking medication to treat the symptoms of PTSD. Medications can effectively treat symptoms associated with PTSD and are not necessarily detrimental to a career in law enforcement.

Similar policies should be developed for military personnel returning from combat deployments. While policies will have similar objectives, the approach to returning combat veterans must be comprised of treatment methods that take into account those who have PTSD from combat and have been subjected to multiple events and/or multiple traumas. One of the greatest benefits to military personnel who have returned from combat is allowing them the time to rest and transition from combat to a normal life again. Military members are able to get psychological counselling through the U.S. Government as well as assistance for spouses and children of the military members to educate them on what the soldier might be facing in the near future if not already.

An agency is required by USERRA to rehire an employee after a deployment and have them return to their last position, as well as any promotions they may have received during the deployment. Positive steps must be taken in the policy to provide a returning soldier with the same opportunities given to a normal officer. After all steps have been taken and it is determined the soldier cannot function in their previous role, it should be indicated in policy as to whether the officer will be reassigned or terminated from their position. The department policy should be flexible enough to give the returning veteran every opportunity to recover from a critical incident or combat trauma, but concrete and decisive enough to terminate the employment if it is determined to be in the best interest of the officer, the department and safety of the citizens of the perspective jurisdictions.

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