

Police Peer Support: Peer support differs from counseling and psychotherapy. Peer support is a non-professional supportive interaction, whereas counseling and psychotherapy traditionally involve a professional relationship with a licensed clinician. Therefore, peer support is best conceptualized as a non-professional interpersonal interaction wherein: (1) a person attempts to assist another person with a stressful circumstance, and (2) the person providing support shares some common background, experience, condition, or history with the person he or she is attempting to help.

Level I and Level II Peer Support

Level I peer support: There are two levels of peer support. **Level I** peer support consists of the support found in the everyday positive interactions of friends, co-workers, and others that have some peer status. Nearly everyone, at one time or another, has been the provider and the recipient of this type of peer support. Level I peer support has a long history and can be thought of as “traditional” peer support. **Level II** peer support is similar to Level I, but Level II peer support includes several important components that are not present, or not necessarily present, in Level I. This makes Level II peer support interactions different from the Level I support that can come from “friends talking.”

Level II peer support: (1) Level II peer support is provided by members of an agency-recognized peer support team functioning within state statute and/or department policy and operational guidelines, (2) Level II peer support is provided by persons trained in peer support, (3) Level II peer support interactions are characterized by elements of functional relationships which encourage exploration, empowerment, and positive change, (4) Advice giving is avoided in Level II peer support - independent decision making is encouraged, (5) Level II peer support is guided by ethical and conceptual parameters – this makes it different than just “friends talking,” (6) Level II peer support has positive outcomes as its goal – this is not always the case in Level I peer support interactions, (7) Peer support team members are clinically advised or supervised by a licensed mental health professional - this provides a “ladder of escalation” if consultation or referral is needed. A structured ladder of escalation is not available in Level I interactions, and (8) Level II peer support, while non-judgmental, includes a safety assessment – it has an evaluative component. If a peer support team member assesses that the recipient of peer support is dealing with an issue that exceeds the parameters of peer support or if it is assessed that the recipient is or may be overly stressed, depressed, or suicidal, the peer support team member is trained to act upon the assessment. This is accomplished by providing information about available resources, making appropriate referrals, moving up the ladder of escalation, or initiating emergency intervention.

Peer support team members capable of providing Level II peer support may continue to provide Level I peer support. Level I peer support occurs when peer support team members are not acting in their peer support team member role. However, when peer support team members are not acting in their peer support team role, the confidentiality privileges afforded to peer support team members during peer support interactions do not apply. Level II peer support, like Level I, may consist of a one-time contact or ongoing meetings. Some police officers and administrators are unclear about the role of a peer support team, especially considering that most modern-day police jurisdictions provide counseling services through health insurance plans and Employee Assistance Programs (EAP). It is not surprising that some police administrators ask, “With employee insurance coverage and an EAP, why do we need a peer support team?” The answer is simple - peer support teams occupy a support niche that cannot be readily filled by either health plan counseling provisions or an EAP. This is because well-trained and highly functioning peer support teams provide support that is qualitatively different than that provided by health insurance therapists or EAP counselors. The difference? The difference is the *power of the peer*. The power of the peer is the factor that is a constant in the support provided by peer support team members. It is the factor that is not, and cannot, be present in any other support modality. Therefore, if an agency wants to do the best it can to support its officers, a peer support team is necessary. Peer support can be initiated early in an officer's career - it can be made available to recruit-officers during basic police academy training as well as incorporated into police officer field training programs.

The Three "Seconds" of Policing

Secondary Danger, Secondary Injury, and Secondary Trauma

The *secondary danger* of policing is the idea that equates “asking for help” with “personal and professional weakness”. *Secondary injury* is the harm that can be caused to officers when they are poorly treated following involvement in a critical incident. *Secondary trauma* — also known as vicarious trauma — refers to the indirect traumatization that can occur when a person is exposed to others who have been directly traumatized. Secondary trauma is a real concern for the spouses and family members of officers that have been involved in a critical incident, as well as previously non-traumatized officers and others participating in departmental critical incident debriefings.

Police Physical/Psychological Primary Danger and Police Secondary Danger

The primary danger of policing has two components: (1) physical primary danger and (2) psychological primary danger.

Physical primary danger. A finalized report of the National Law Enforcement Officers Memorial Fund (NLEOMF) website shows a total of 129 police officer line-of-duty fatalities in 2012. Of these, 52 are specified as “traffic-related”. This is in contrast to 49 officer deaths specified as “firearms-related”. The remaining 28 officer deaths are attributed to “other causes.” This is a reported decline of 22% compared to 2011, when 165 officers died in the line of duty (72 firearms-related, 60 traffic-related, 33 other causes). (The NLEOMF reported 124 police officer line-of-duty deaths in 2015.) These fatalities are representative of the *physical primary danger* of policing. The physical primary danger of policing is comprised of the inherent, potentially life-threatening risks of the job, such as working in motor vehicle traffic and confronting violent persons.

Psychological primary danger. The *psychological primary danger* of policing is related to, but distinguishable from the physical primary danger of policing. The psychological primary danger of policing is represented in the increased probability that due to the nature of policing, officers will be exposed to critical incidents, work-related cumulative stress, and human tragedy. This higher probability of exposure results in an increased likelihood that officers will suffer psychological traumatization and stressor-related disorders. It is the increased likelihood of psychological traumatization and the increased likelihood of experiencing stressor-related disorders that comprises the psychological primary danger of policing. Another way of saying this is that the physical primary danger of policing constitutes a work environment that generates the psychological primary danger of policing.

Secondary danger. Sadly, there is also an insidious and lesser known *secondary danger* of policing. The secondary danger of policing is often unspecified and seldom discussed. It is an artifact of the police culture and is frequently reinforced by police officers themselves. It is the idea that equates “asking for help” with “personal and professional weakness.” Secondary danger has been implicated in perhaps the most startling of all police fatality statistics, the frequency of police officer suicide. The National Study of Police Suicides (NSOPS) reported that 126 police officers killed themselves in 2012 (the last year in which NSOPS collected police officer suicide data). As tragic as this is, it represents the first decline in police officer suicides since the study began in 2008, when 141 officer suicides were reported. By comparison, in 2009, 143 officer suicides were recorded. In one sense, when compared to the number of officers killed by felonious assault and killed by accident, suicide is truly the number one killer of police officers. In fact, for the years in which there is NSOPS officer-suicide data (2008, 2009, & 2012), the number of police suicides exceeded the number of officer deaths from felonious assault and accidents *combined* (based upon statistics reported by Officer Down Memorial Page - excluding officers that died as a result of 9/11/2001 related illness and heart attack). In January, 2016 the NSOPS resumed its study of law enforcement officer suicides.

Make it Safe Police Officer Initiative

The Make it Safe Police Officer Initiative encourages:

- (1) every officer to "self-monitor" and to take personal responsibility for his or her mental wellness.
- (2) every officer to seek psychological support when confronting potentially overwhelming difficulties (officers do not have to "go it alone").
- (3) every officer to diminish the sometimes deadly effects of secondary danger by reaching out to other officers known to be facing difficult circumstances.
- (4) veteran and ranking officers to use their status to help reduce secondary danger (veteran and ranking officers can reduce secondary danger by openly discussing it, appropriately sharing selected personal experiences, avoiding the use of pejorative terms to describe officers seeking or engaging psychological support, and talking about the acceptability of seeking psychological support when confronting stressful circumstances).
- (5) law enforcement administrators to better educate themselves about the nature of secondary danger and to take the lead in secondary danger reduction.
- (6) law enforcement administrators to issue a departmental memo encouraging officers to engage psychological support services when confronting potentially overwhelming stress (the memo should include information about confidentiality and available support resources).
- (7) basic training in stress management, stress inoculation, critical incidents, posttraumatic stress, police family dynamics, substance use and addiction, and the warning signs of depression and suicide.
- (8) the development of programs that engage pre-emptive, early-warning, and periodic department-wide officer support interventions (for example, proactive annual check in, "early warning" policies designed to support officers displaying signs of stress, and regularly scheduled stress inoculation and critical incident stressor management training).
- (9) law enforcement agencies to initiate incident-specific protocols to support officers and their families when officers are involved in critical incidents.
- (10) law enforcement agencies to create appropriately structured, properly trained, and clinically supervised peer support teams.
- (11) law enforcement agencies to provide easy and confidential access to counseling and specialized police psychological support services.
- (12) police officers at all levels of the organization to enhance the agency climate so that others are encouraged to ask for help when experiencing psychological or emotional difficulties instead of keeping and acting out a deadly secret.

If law enforcement officers wish to do the best for themselves and other officers, it's time to make a change. It's time to make a difference.



The 2 and 2

The "2 and 2" is a simple way to characterize an anxiety coping strategy that has proven useful in the management of the reactivity that sometimes follows the exposure to a critical incident. **The first "2" is "I know what this is, I know what to do about it". The second "2" is "stronger and smarter."**

The 2 and 2 works like this: When a person experiences anxiety upon exposure to a critical incident-associated personal or environmental trigger, he or she quickly brings to mind the first "2" - "I know what this is, I know what to do about it. This is a current response to something connected to my past. I am not confronting danger now, therefore I do not need this feeling. I need to engage my anxiety coping mechanisms." (The person then engages previously learned anxiety management techniques). As anxiety management techniques are being utilized, the person accesses the cognitive notion of becoming stronger and smarter (because the alternatives are unacceptable). When used simultaneously, each "2" of the 2 and 2 combine to comprise a simple, yet powerful cognitive, emotional, behavioral, and physiological tool to manage post-traumatic stress and anxiety.

The Time Machine

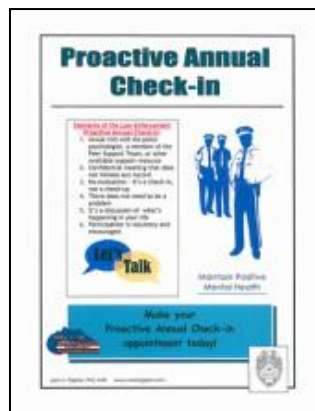
Peer support issues and strategies: Support intervention as the 2nd best option (time machine = the best option). "With a time machine we could go back with what we now know and prevent a critical or undesirable incident. Being that the best option is not available, we must work together to do the best we can to move forward." (this simple cognitive presentation often helps officers to diminish the wishful thinking that is sometimes present following a critical incident. It helps officers move past wishing that the incident did not happen. It helps officers to focus on the "here and now" and eventual recovery (From: *Contemporary Issues in Police Psychology*, page 63)

Proactive Annual Check-In

The **Proactive Annual Check-In (PAC)** provides police officers and other agency employees with a confidential setting within which to share information about current life circumstances. It is a proactive program designed to offer a positive exchange of thoughts, ideas, and information.

Elements of the Proactive Annual Check-In:

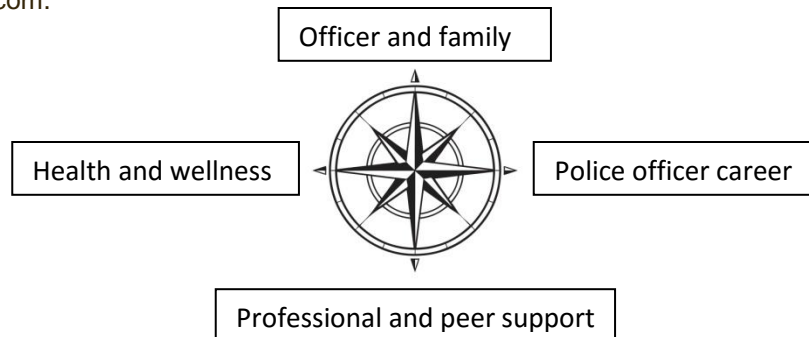
(1) Annual visit with the staff psychologist, a member of the Peer Support Team, department Chaplain, private counselor, or other support resource, (2) Confidential meeting that does not initiate any record, (3) No evaluation - It's a *check-in*, not a *check-up*, (4) There does not need to be a problem, (5) It's a discussion of what's happening in your life, (6) Participation is voluntary and encouraged.



Comprehensive Model for Police Advanced Strategic Support

The **Comprehensive Model for Police Advanced Strategic Support** (COMPASS) begins with the organizational climate and pre-hire psychological assessment. It continues with career-long support considerations that extend beyond retirement.

COMPASS is flexible. Law enforcement agencies can modify COMPASS to best provide comprehensive officer-support within available resources. A graphic outline of COMPASS is included in *Contemporary Issues in Police Psychology*, the *Law Enforcement Critical Incident Handbook*, and the *Police and Sheriff Peer Support Team Manual*. The COMPASS graphic outline may also be downloaded from www.jackdigliani.com.



COMPASS – *Helping police officers to find their way*

Other People Are Not You

Who would disagree? Other people are not you. But knowing this and understanding it is very different. These conceptualizations can have major life impact.

Surface lesson – Deep lesson

Surface lesson: casual knowledge. Deep lesson: mindful knowledge – knowledge that is applied in one's life and makes a difference in intrapersonal and interpersonal transactions.

Other people are not you has implications for *Life by Design* and *Life by Default*.

At times, others will wait when you would act. They will act when you would wait. They might remain in circumstances that you would abandon, and abandon circumstances in which you would remain. This is because, due to many factors, there is a wide range of variability among individuals.

There are five primary factors that make it possible for you to “know” what other persons should do in circumstances that create indecision for them:

- 1) Different personal histories
- 2) Differences in actual or perceived abilities
- 3) Personal value and belief system differences
- 4) You do not have the emotional investment or attachments that exist for them
- 5) You will not experience the real-life consequences that they will experience upon making a decision

Therefore, the personal process of making any significant life decision is fundamentally different for the involved person than it is for any outside observer. Personal evaluation: Other people are not you is often a factor in your evaluation of other's behavior as it relates to you, “I would not have done that”, “I would have not done that to you” and differences in what you and others may value.

Peer Support Team Code of Ethical Conduct

As a member of an agency peer support team I am committed to the highest standards of peer support. I knowingly accept the responsibility associated with being a member of a peer support team.

Peer support team members:

1. engage in peer support within the parameters of their peer support training.
2. specify when they are functioning in their peer support role, and if uncertain whether an interaction is peer support, they inquire to clarify.
3. keep themselves current in all matters of peer support confidentially.
4. disclose peer support information only with appropriate consent, except in cases where allowed or mandated by law; and if uncertain whether disclosure is appropriate, consult with their clinical supervisor prior to disclosing information.
5. clearly specify the limits of peer support confidentiality prior to engaging in peer support.
6. remain aware of potential role conflicts and are especially vigilant to avoid role conflict if in a supervisory position.
7. make a reasonable effort to attend scheduled team meetings and programs of in-service training.
8. make referrals to other peer support team members, their clinical supervisor, and others when appropriate.
9. are careful providing peer support for persons with whom they have a troubled history. If the history cannot be overcome, they provide appropriate referral.
10. comply with peer support team statutes, policies, and operational guidelines.
11. do not utilize their peer support role for personal gain or advantage.
12. do not engage in inappropriate behaviors with those for whom they are providing peer support.
13. contact their clinical supervisor immediately with any perceived role conflict, ethical issue, or possible conflict of interest arising out of peer support.
14. seek immediate clinical supervision and consultation in any circumstance that reasonably exceeds the assessment and parameters of peer support.
15. reach out to others they know or suspect may benefit from peer support.
16. make reasonable effort to respond to individual requests for peer support and to respond to critical incidents as needed.
17. seek support from other peer support team members, their clinical supervisor, or other support personnel when stressed or otherwise in need of support.
18. are committed to helping other peer support persons to become better skilled. They do this by readily sharing their knowledge and experience when it does not conflict with the standards of peer support confidentiality.
19. endeavor to maintain a positive relationship with their clinical supervisor and other peer support team members, and make an effort to resolve any issues of conflict that may arise in these relationships.
20. understand that they are perceived as role models and that their actions reflect upon the entire team.
21. utilize self-enhancement peer support concepts in their personal lives.

(Digliani, J.A., 5/2015)