U.S. DEPARTMENT OF JUSTICE

President's Commission on Law Enforcement and the Administration of Justice

Hearing on Officer Safety and Wellness

February 27, 2020 • Miami, Florida

Witness Biographies and Testimonies

HEARING ONE
Law Enforcement Health and Wellness
Miami, Florida
February 27

8:00 AM **Commission Executive Session**
Jasmine Ballroom
Briefing on Hearing procedure

10:00 AM **AG Remarks at IACP Officer Safety and Wellness Symposium**
Commissioners seated in front row

10:30 AM **Opening Ceremonies at IACP Symposium Conclude**
Commissioners depart Opening Ceremonies; Assemble in Jasmine Ballroom

10:45 AM **President's Commission on Law Enforcement and the Administration of Justice Hearing on Officer Health and Wellness**

Call to Order and Welcome
Phil Keith, Chair

10:50 AM **Opening Statements by Commissioners**

11:05 AM **Panel One—Framing the Issue**

- **William Gross, Commissioner, Boston, Massachusetts Police Department**
  Corey Nooner, Oklahoma City, Oklahoma Police Department
  Co-Chairs, Police Officer Health Working Group
- **Patrick Yoes, National President**
  Fraternal Order of Police
- **Alexa James, Executive Director**
  National Alliance on Mental Illness-Chicago
- **Fred Farris, Chief of Police**
  Goddard, Kansas Police Department
- **Steve Casstevens, President**
  International Association of Chiefs of Police

11:55 PM **Lunch on Your Own**

1:10 PM **Call to Order**

1:10 PM **Panel Two—Experts**

- **Scott Coyne, MD, Medical Director**
  Suffolk County, New York Police Department
- **William King, Professor**
  Boise State University
- **Alexander Eastman, MD**
  Dallas, Texas Police Department

1:40 PM **Panel Three—Promising Practices**

- **Nicole Juday, Officer**
  Indianapolis, Indiana Police Department Police Wellness Program
- **Sherri Martin, Director, Law Enforcement Mental Health and Wellness**
  Fraternal Order of Police
- **Mick McHale, President**
  National Association of Police Organizations

2:20 PM **Break**

2:30 PM **Panel Four—Support**

- **Karen Solomon, President**
  Blue H.E.L.P.
- **Janice McCarthy, President**
  Care of Police Suicide Survivors
- **Stephanie Samuels, Founder**
  COPLINE
- **Cherie Castellano, Program Director**
  Cop2Cop
- **Dianne Bernhard, Executive Director**
  Concerns of Police Survivors

3:30 PM **Testimony Concludes**

3:30 PM **Closing Comments**
Phil Keith, Chair
Katie Sullivan, Vice Chair

3:45 PM **Commission Executive Session**

4:45 PM **Adjourn**

William Gross

Boston Police Department

William Gross is the City of Boston's first African American Commissioner. Gross is a 33-year veteran of the Boston Police Department. As a Patrol Officer he spent many years in the Gang Unit and Drug Control Unit, as well as serving as an Academy Instructor. He rose through the ranks, achieving the ranks of Sergeant and Sergeant Detective, and was promoted to Deputy Superintendent in 2008, where he became a member of the Command Staff of the Department.

As Deputy Superintendent, Gross served as the Commander of Zone 2, which is comprised of Area B-2 Roxbury and Mission Hill, Area B-3 Mattapan, Area C-11 Dorchester, and Area C-6 South Boston. In this role, he coordinated with District Captains in their development of strategies to address crime trends, and attended community meetings to address specific neighborhood crime concerns.

In 2010, Deputy Superintendent Gross became the commander of the Field Support Division, which included command over the Youth Violence Strike Force (Gang Unity), and the School Police Unit. In 2012, he was promoted to Superintendent, Night Commander, responsible for oversight of all police responses to incidents on a citywide basis in the evening hours. Throughout his career, Superintendent Gross has maintained a strong connection with the community, and has been awarded numerous awards for bravery, meritorious service and community partnership.

Testimony of Boston Police Commissioner William G. Gross
President's Commission on Law Enforcement and the Administration of Justice
Hearing One – Officer Safety and Wellness
Miami, Florida
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I would like to thank President Trump for the strong support he has shown to law enforcement and for prioritizing the issue of officer safety and wellness within this important commission.

I would also like to thank the Attorney General, Chairman Keith and the many law enforcement officials here with us today.

Thank you to the IACP for hosting the symposium and for continuously elevating officer safety and wellness nationally.

And a special thank you to the Commissioners and members of the Officer Safety, Health and Wellness Working Group.

We had a very productive meeting yesterday about a very serious topic.

As the Police Commissioner of Boston, nothing is more important to me than the wellbeing of my officers. They are the backbone of what I believe is the best police department in the country. I'm sure you all feel the same way about your officers.

It has never been an easy time to be a police officer in America, but it is especially difficult now. The anti- police sentiment and lack of trust in law enforcement in some communities impacts all of us. It is harmful and it is dangerous.

We are all the same – urban, rural, tribal; from east to west and north to south. We are guardians, our job is to keep people safe. We need to make sure we are also keeping ourselves safe – physically, mentally and emotionally.

Unfortunately, the work we do takes a tremendous toll. Police officers witness far too many tragedies and traumatic incidents, far too much desperation and despair, and far too much sadness and grief during the course of their careers.

The impact of these events in isolation as well as the compounding effect over time to officers' physical and mental wellbeing are well documented.

PTSD, vicarious traumatization, secondary traumatic stress, high rates of heart disease, diabetes and substance abuse. This list goes on an on.

And sadly, the suicide rate of police officers continues to climb.

Hearing from Commissioner Frazier yesterday about the tragic assassination of Dallas police officers four years ago and the lasting impact it has had on the entire department was compelling.

And hearing from Chief Kehoe from Newtown regarding the Sandy Hook elementary school tragedy and the long-term effects on his officers was undeniable.

We must do all we can to provide the resources officers need, as well as removing the stigma associated with seeking or accepting help. And we need to encourage co-workers and family members to seek help for officers they think are in trouble.

The formation of the Working Group on Officer Safety, Health and Wellness could not have come at a better time.

Our meeting yesterday provided a forum for discussing the issues and highlighting solutions and best practices.

Suicide prevention programs, confidential mental health counseling, critical incident training, and peer support programs are just a few of the solutions we discussed.

We should also be mindful of including community engagement in this discussion. Improving trust and relationships with the community improves the lives of police officers. This cannot be understated.

We are looking forward to finalizing our recommendations in the coming weeks and months.

Thank you.

Corey Nooner

Oklahoma City Police Department

In 1997, I was hired by the Oklahoma City Police Department where I began my career as a police officer. I worked hard to understand the basics of police work and earn the respect of my fellow officers. While working in patrol, I had regular contact with many of the homeless who suffered from mental illness and wandered the downtown district.

In 2000, I was involved in an officer involved shooting. During this incident I shot and killed an individual. The individual was armed with large knife and was walking outside an elementary school where children were present. After the incident I was informed that the individual I shot suffered from mental illness. My shooting incident was ruled justified by the local district attorney but this incident affected me in many ways.

In 1997, when I joined the police department I became a member of the Fraternal Order of Police (FOP). In 2010, I was elected as Treasurer of my local lodge in Oklahoma City. I still hold this office in my local lodge and oversee a budget of almost $1 million. In 2012, I was elected as the State Secretary for the Oklahoma FOP and I held that office until 2018 when I was elected as the State Treasurer. I am also a member of the National Fraternal Order of Police Officer Wellness Committee.

Military Experience:
1989 - 1995 • Oklahoma Army National Guard (Operation Desert Shield / Desert Storm Veteran)

Education:
1997 • Oklahoma City Police Academy
2001 • Basic CLEET Instructor
2002 • Crisis Intervention Team Trainer
2003 • Advanced CLEET Instructor
2005 • Cameron University • Bachelor of Science in Criminal Justice

Employment:
1997 to Current • Oklahoma City Police Department

- Currently assigned to patrol duties as a Master Sergeant with Southwest Division where I work patrolling the southwest area of Oklahoma City.
- Since 2002, I have worked as a Crisis Intervention Team officer and trainer. This job assignment requires me to respond to mental health calls for service and provide resources to those in need. I have also developed and provided training to officers regarding first responder mental health.

I must first say that I am honored to have been selected as co-chair of the Safety, Health and Wellness working group within the President's Commission on Law Enforcement and the Administration of Justice. As a representative of the Fraternal Order of Police, I look forward to discussing the significant issues that are facing law enforcement across the United States and I believe that we will develop a plan that will help all officers regarding these issues.

Almost 23 years ago I sat in a classroom in the Oklahoma City Police Department as an officer in training. My palms were sweating and my heart was racing at the thought of what was in front of me. It was the beginning of a journey that I had dreamed of my whole life. I always knew I wanted to be a police officer, I just did not know where or when it would happen.

As I started my career in law enforcement I quickly discovered that the emotions I was dealing with were at times overwhelming. As I saw the suffering of the people that I encountered on patrol I was forced to find a way to process those feelings. I see this daily grind of emotional management to be the most challenging for all law enforcement. I leaned upon the training I was provided to prepare me for this and the support of veteran officers.

Early in my career I was selected to be part of the first group of officers trained in the Memphis model of Crisis Intervention Team (CIT) Training by the Oklahoma City Police Department. CIT training helps officers to understand mental illness and to evaluate individuals to determine if they need forced hospitalization. I was selected as a CIT trainer and have assisted in the training of hundreds of officers across Oklahoma in the last 15 years. CIT training gave me more confidence to help the people I encountered on patrol. I also used the training to help my fellow officers to understand their own mental health issues.

According to the National Alliance on Mental Illness, one in five adults will be affected by mental illness each year. Just four years ago I became part of that statistic as a family member began having significant issues with depression and suicidal thoughts. With my training and experience in these issues I felt more than equipped to find the resources to insure that my loved one got the support and treatment they needed. I worked desperately to assemble the resources needed to keep my family member out of hospitalization. I did everything humanly possible, but I failed.

My family member was hospitalized because of the suicidal plans that were made. In that moment I to was affected mentally. I found myself in a condition that I was not fit for duty and I found myself calling my immediate supervisor to discuss this. I knew what was supposed to happen but I was terrified. I sat down in that meeting and ask for the support that I desperately needed. Fortunately my command supported me. I cannot

express what a relief it was to leave knowing that my department was standing by me in this difficult time. My family member began the path to recovery and I to began to process the feelings of failure. I also became overwhelmed by the stigma of saying that I was struggling with a mental health issue and I needed help.

This issue of stigma is powerful and we need to work diligently to destroy this. Unfortunately some departments still respond punitively to officers asking for help. Many agencies fail to educate officers on the healthy ways to deal with the emotions they experience. This leads to officers failing to address these mental health needs. Regrettably, far too often, these officers succumb to depression and take their own lives in a last desperate attempt to relieve themselves of the pain they are experiencing.

Law enforcement agencies need to make supporting officers experiencing mental health issues a priority in both word and action. Law enforcement representatives from across the nation need to speak loudly and regularly about the difficulties of the events that law enforcement officer's experience. We must make it our mission to ease the burden of not only the officer but their family as well.

Law enforcement officers and their families are not immune to the statistic that I mentioned above. It is the humanity within each officer that makes them a great officer. It allows them to both logically work through a critical incident and show empathy to the victim of a crime. Humanity also makes them vulnerable and that is what we must help them with.

I would like to pull back my focus just a bit regarding mental health. This is a national issue. We are all too familiar with the increasing rate of suicide within the military. Mental health needs to be a priority for our nation as a whole. This issue is tied to incarceration rates, domestic violence, and childhood trauma.

I welcome the opportunity to talk about the issues the law enforcement community faces. I hope that we will be able to provide some solutions to the issues I have summarized.

Respectfully,
Corey Nooner
Oklahoma Fraternal Order of Police - State Treasurer
Oklahoma City Police Master Sergeant
Email: voice1154@cox.net

Submitted: February 20, 2020

Patrick Yoes

National President

Patrick Yoes has dedicated his life to the service of others. He has been an active member in the Fraternal Order of Police for over 35 years. Over his career Patrick has served on commissions and charitable and community service boards. He is a strong law enforcement advocate. He has held leadership positions on his local, state and national Fraternal Order of Police boards.
Patrick's unwavering path of service includes a commitment to education—his own as well as others. With degrees in Criminal Justice and Organizational Leadership, and a graduate of the FBI National Academy, his passion is empowering others with the tools to succeed.

An active law enforcement officer, Patrick is employed by the St. Charles Sheriff's Office, the sole law enforcement agency for St. Charles Parish, Louisiana, a suburb 18 miles west of New Orleans, LA. Patrick has oversight of the department's Special Services Division responsible for a number of community outreach programs. He also serves as the agency's Public Information Officer. During his career with the agency, Patrick has worked as a patrol deputy, patrol sergeant, school resource officer, and detective in the criminal investigation division, becoming commander of the Special Services Division.

Since joining the St. Charles (LA) local lodge #15 in 1984, he has held nearly every elected position, including eight terms as Lodge President. Patrick is also active on the state level, having served on the Louisiana State Lodge Executive Board for more than 22 years, ten as President. He is presently serving as Immediate Past President.

In 2000, Patrick was recognized as the National Fraternal Order of Police Jack Dudek Member of the Year in recognition of his service and dedication to his community, his department, and the FOP on the local, state and national levels.

In 2003, Patrick was elected National Sergeant-at-Arms; Patrick was then elected National Secretary in 2004. He passionately served as your National Secretary for 14 years prior to being elected President at the 64th Biennial Conference in 2019.

As President, it is Patrick's mission to lead the Order in these changing times and finding solutions to the real issues facing our profession and our members.

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PATRICK YOES
NATIONAL PRESIDENT

JIM PASCO
EXECUTIVE DIRECTOR

Patrick Yoes, National President
Fraternal Order of Police
Focus area: Officer Safety, Respect for Law Enforcement, Mental Wellness
Topics addressed: Ambush attacks on law enforcement, causes, and response

Thank you, Director Keith and distinguished members of the Presidential Commission on Law Enforcement and the Administration of Justice. My name is Patrick Yoes, National President of the Fraternal Order of Police, which is the largest law enforcement labor organization in the country. I am the elected spokesman for more than 350,000 rank-and-file law enforcement officers.

I am very pleased and honored to be asked to appear before this distinguished Commission. The FOP was proud to have played a pivotal role in its establishment and we are very supportive of its work. Today, I would like to discuss a vital officer safety issue—the continued increase of deliberate, targeted attacks on law enforcement officers. Too often, the badge and the shield have become targets and too many officers are paying the ultimate price for nothing more than the uniform they wear.

In 2019, 293 officers were shot in the line of duty, 50 of whom were killed. The number of officers shot in an ambush attack increased to 30 last year and seven of those officers were killed. The number of officers shot in the line of duty went up 20% in 2019. Fourteen percent (14%) of the officers killed by gunfire in 2019 were killed in an ambush attack.

The number of fatalities from gunfire has, apart from a sharp upward spike in 2016, remained relatively consistent in recent years. However, gunfire fatalities are a misleading metric because the number of attacks against law enforcement has been *rising* since at least 2012. Thanks to advances in medical trauma science and anti-ballistic technology these incidents have become more *survivable*, but the number of attacks on officers is still increasing.

In 2015, the Office on Community Oriented Policing Services issued a report on the first serious study of ambush attacks on law enforcement entitled *Ambushes of Police: Environment, Incident Dynamics, and the Aftermath of Surprise Attacks against Law Enforcement.*[1] The study made the following recommendations:

[1] Fachner, George & Thorkildsen, Zoe. (2016). Ambushes of Police: Environment, Incident Dynamics, and the Aftermath of Surprise Attacks Against Law Enforcement.

- The U.S. Department of Justice (DOJ) should clearly define what constitutes an ambush attack and collect data on these incidents;
- More research is needed into the causes of violence against law enforcement;
- Systematic critical incident reviews should be institutionalized through the profession of law enforcement;
- Reality-based training is the best way to prepare officers to survive an ambush attack; and
- The DOJ, working with law enforcement agencies, policy and research institutions should commit resources to develop training and tactics to assist officers in preparing for, and surviving, ambush attacks.

The FOP agrees with these recommendations and, beginning in late 2015, the FOP took it upon ourselves to track and record the number of officers who were shot in the line of duty and, to the extent that we were able, to identify which attacks were ambushes. We are pleased that, beginning in 2018, the COPS Office, under the auspices of the National Blue Alert Program, began tracking this data as well, issuing their first report in 2019. The FOP recently received a Federal grant to assist in the collection and analysis of this data. We look forward to our continued partnership on this important project, which we believe to be necessary because it is data that was not captured in a comprehensive way. The existing program administered by the Federal Bureau of Investigation (FBI) that collects data on officers killed, assaulted and injured (LEOKA) in the line of duty relies entirely on the voluntary disclosure of this information by individual jurisdictions. Too many agencies do not share this information with the FBI and we urge the Commission to look for ways to ensure greater compliance with the LEOKA program.

Now that we have established that attacks on officers have been increasing, the question remains: how did we get here? How did we reach a point in our communities that law enforcement officers, once universally respected as "Officer Friendly"—a figure parents would urge their children to seek out if they were ever in trouble—to being the subject of such distrust and disdain? I believe it began with simple rhetoric. The resurrection of old slurs against police—calling us pigs or other vile names as they did during the national turmoil of the Vietnam War era. Anti-police groups held marches, protests, riots—all with the primary objective to denigrate, disrespect and dishonor the men and women of law enforcement. The mainstream media, nationally and locally, amplified the voices of these fringe groups and, unsurprisingly, these verbal assaults and "protests" turned into action. Deliberate, targeted attacks on law enforcement increased each year, even as we worked to better protect our communities. Consider the fact that the mass murder, perpetrated on the officers of the Dallas Police Department, occurred while these officers were protecting an orderly group peacefully protesting police actions.

So far this year, a group of law enforcement officers in Honolulu were ambushed, resulting in the deaths of Officers Tiffany-Victoria Enriquez and Kaulike Kalama. An officer in Santa Clara, California, was ambushed in late January. In February, two officers with the New York City Police Department were shot in an ambush attack, but miraculously, they both survived.

The hostility toward law enforcement is not just limited to those who attack officers, but is also demonstrated by the public at large. Last summer in Sacramento, California, a gunman ambushed two deputies responding to a domestic violence call and shot 27-year old Tara

O'Sullivan. Her fellow officers raced to the scene and, while actively engaged in a gun battle, bystanders—the very public they were there to protect—were berating and mocking the officers during this incident while one of their own laid injured and still in the line of fire. It took 45 minutes to rescue Deputy O'Sullivan who died at the hospital from her injuries.

In Philadelphia last August, officers serving a warrant were suddenly fired upon by a gunman. The shooter trapped two officers in the building and shot a total of six officers. It was a miracle that none of those officers were killed that day. While responding officers were actively engaged in this active shooter situation, they were verbally harassed by the local community members and had to seek cover from not just the shooter, but from the community members hurling objects at them. The very next day there was a rally in Philadelphia, not in support of the injured heroes of the city's police department, but in support of the man who tried to kill them.

Elected officials at every level of government have embraced attacks on the profession of law enforcement. Members of the House of Representatives have called for the Immigration and Customs Enforcement (ICE) to be disbanded. State Governors have pushed legislation limiting or restricting police use of force options, putting officers and the public in greater jeopardy. As of 1 January 2020, New York State law prohibits judges from setting bail for a long list of crimes—including using children to sell drugs, stalking, burglary and possession of a firearm on school grounds. Judges will be required to release these offenders back into our communities until trial. We have already seen several incidents where dangerous criminals have been set free as required by law, only to reoffend before they even go to trial on the original offenses.

The most recent development is even more troubling—activist district attorneys who are not only embracing anti-police rhetoric, but are actively undermining local law enforcement and, as a result, the safety of the public at large. Local prosecutors are quick to bring indictments against law enforcement officers for misconduct while dropping case after case against repeat offenders facing charges for drug trafficking, weapons violations and even violent crime. In far too many of our major cities, prosecutors are failing to do their jobs, choosing not to prosecute persons that we know pose a threat to the public. This is a dangerous trend.

These shameful acts are an example of the harm being done by the changes in our attitudes toward police officers. It seems we have moved from a lack of support and respect for our police officers to outright animosity. We are public servants, not public enemies—and yet, the attacks continue to increase every year.

The FOP has called on Congress to act to reduce this type of targeted violence by once again passing H.R. 1325, the "Protect and Serve Act." This bill would make it a Federal offense to target a law enforcement officer with violence in certain, limited circumstances. It would not make every attack against an officer a Federal crime, but it would give the U.S. Department of Justice a tool to fight back against targeted attacks on police like those in Dallas and Baton Rouge.

In 2018, the House Committee on the Judiciary passed identical legislation unanimously before being approved by the House by an overwhelming vote of 382-35. I urge the Commission to

review this legislation and consider making its adoption one of the Commission's recommendations.

The changing attitudes toward law enforcement are not just endangering the men and women in law enforcement—they are triggering escalations in normal, everyday police-community interactions. On any given day in America, there are over 2 million police/public interactions. When we interact with a member of the community who refuses to comply with an officer's directions, perhaps because of their perspective of police, the situation escalates and, as we have seen, can sometimes have tragic results.

While law enforcement continues to push for more focus on de-escalation strategies and training, officers are encountering increased belligerence and uncooperativeness more often. This increases the risk of physical harm to the members of the community, the officer and innocent bystanders. This must stop—people must comply with an officer's reasonable directions. We expect our officers to adhere to certain policies and protocols when answering a call for service or interacting with the public and we need—in fact, we depend upon—the cooperation of the citizens we protect to ensure a positive outcome.

While we strive to continue to learn about and prepare for the physical threats that law enforcement officers face in the line of duty from ambush attacks and the routine physical demands of the job, we also need to learn more about how to protect officers from the mental and spiritual stress and damage inflicted on them. Law enforcement officers see the very worst of humanity, with some studies suggesting that a police officer will experience more traumatic events in six months than the average person will experience in a lifetime. One in every five officers is suspected to have Post Traumatic Stress Disorder (PTSD) which can lead to deterioration of heart arterial health, hormonal imbalances and depression, which far too often leads to suicide.

Consider this: the average life expectancy for an American is 78.7 years. The average life expectancy of a police officer is ten years less. First responders are five times more likely to experience PTSD and depression than civilians, and the number of suicides among law enforcement officers seems to be grossly under reported. In 2019, approximately 228 law enforcement officers took their own lives. In contrast, 50 officers died after being fatally shot in the line of duty last year.

I hope that my testimony here today will assist the Commission in its work. I thank you all again for this opportunity and would be pleased to answer any further questions.

Alexa James, LCSW

NAMI Chicago

Alexa James assumed the role of Executive Director of NAMI Chicago in 2014. In her time as Executive Director, Alexa has made NAMI Chicago a leading voice in the conversation around mental wellness, challenges of the mental health system, and mental health education in Chicago and beyond. Under Alexa's leadership, NAMI Chicago has built partnerships extending throughout Chicago and Illinois that strengthen our community's response to mental health-including by emerging as a trusted partner and expert with Chicago's first responder agencies, the Office of the Mayor, mental health providers, and community stakeholders.

Alexa has represented NAMI Chicago on the Police Accountability Task Force under Mayor Rahm Emanuel, the Health & Human Services Transition Committee under Mayor-elect Lori Lightfoot, and on several appearances on local media, including "Chicago Tonight" on WTTW and multiple pieces in the Chicago Tribune. Alexa has grown NAMI Chicago's presence in the community, not only in media and partnerships, but by building a foundation for organizational growth that has particularly expanded NAMI Chicago's Helpline services and community outreach capacity.

NAMI Chicago's message is at the heart of Alexa's leadership: that with courage and hope, we can bring healing to those who are overlooked in our mental health system, and in our society. In the 10 years prior to her appointment as Executive Director, Alexa worked with children and adults living with mental health conditions as well as those impacted by poverty and trauma. Alexa earned a Bachelor's Degree in Psychology and a Master's Degree in Social Work from Loyola University, as well as a Master's Degree in Child Development from Erickson Institute.

Alexa James
Executive Director
NAMI Chicago
Focus Area: Officer Health and Wellness

Our work at NAMI Chicago focuses on supporting all people in their journey around mental wellness, building on the resilience of community members so they can achieve wellness and working together with our partners to shift the perspective around mental health. Our longest and strongest partnership is with the Chicago Police Department – and this is not by accident. Across this country, our mental health systems are often the crisis system and first responders. Police officers have become the safety net for mental health services and transport as years of disinvestment have eroded the community mental health system. As we know in Chicago, we have strong mental health provider partners, but they cannot meet significant and growing demands for mental health services. For individuals who lack connection to treatment, the intervention point is often the point of crisis, and so we turn to law enforcement.

We know this must end. The strain on the crisis system is not sustainable and frankly, this is not the job for law enforcement. This is important context for understanding how NAMI Chicago began our partnership with the Chicago Police Department.

Over the last decade supporting and training CPD officers, we've become more deeply engaged in the mental health and wellness of officers themselves. Our original partnership with our local police departments and county sheriff focused on training. Specifically Crisis Intervention Team Training (CIT0 / de-escalation). What we see in CIT every week is the toll mental health conditions are playing on officers themselves and their families, as they routinely disclose their personal situations to me and my team. We decided that even though the training does allow officers to better protect themselves and those experiencing mental health crises, they can't effectively use a skill if they are not well. This has led us to focus specifically on officer wellness in our work, advocating for systemic change within the Department, and offering support to officers directly who are entering or navigating the mental health system. We have now changed the way we teach, to normalize not just the experience of those in the community in crisis, but by prioritizing their own health. Due to this, NAMI Chicago prioritizes normalizing first responder mental health in each training we do, from teaching about compassion fatigue at roll calls across to the city to discussing mental wellness in 4 hours blocks with Chicago Police Department supervisors.

With that in mind, I would like to raise the following recommendations for the Commission to consider in this important work.

1. Law enforcement agencies must review Pre-Service activities related to mental wellness and ensure robust pre-service programs for all officers.
2. Law enforcement agencies must develop policies for On-the-Job Supports related to mental wellness, including developing needed programs and providing training to support implementation.
3. Systemic change is needed within law enforcement agencies to normalize mental health conditions and the experience among officers. This requires cultural change at all levels of agencies and relies on specific strategies to address systemic issues.

We feel a part of the law enforcement family and I personally feel deeply saddened, responsible, and full of grief when I learn an officer has reached such hopelessness that they took their own

Alexa James
Executive Director
NAMI Chicago
Focus Area: Officer Health and Wellness
life. We have pushed policy change, recommendations, and therapeutic supports and traveled the country examining officer wellness programs. And when we felt powerless after yet another suicide last year, we wrote a love letter to the department that was published in the Chicago Tribune. This is our message to our community, knowing our first responders are often not given the love they need and deserve.

I would like to briefly dive into the recommendation areas to provide additional detail on the needed policy and procedural changes from my perspective.

First, law enforcement agencies should focus on building robust pre-service activities that address mental health and wellness and set the stage for service throughout an officer's career.[1] Our recommendation is that at the pre-service/recruit level, we must begin to incorporate conversations that normalize mental health. Further, we must standardize these conversations into professional development opportunities throughout the officers' career tenure. For example, in Chicago, the directive for handling community members experiencing a mental health crisis is specific and prescriptive. However, the policy of the Department when an officer is in a mental health crisis does not follow the same directive. This is a dissonance between how officers respond to and conceptualize community mental health crises versus their own. It is not only confusing for the officer, it further separates how officers perceive those who are "mentally well" and "unwell."

To clarify, we use the SAMSHA recovery model for our wellness frame.[2] We realize that mental wellness is not just about how many therapists the officer has assess to, but also do they have working equipment, a consistent boss, a supportive community and clear understanding of their purpose.

- Mental health is often discussed after-the-fact; after a critical incident has occurred, or after mental health is identified as a problem. There needs to be a strategy around prevention of acute mental health and trauma, intervention that is best practice, and post-vention. An important first step is to normalize mental health care and the realities of the job, such as the impact of trauma exposure and symptoms associated with it. We can't keep law enforcement from experiencing trauma, but we can help build resilience and normalize. They go through significant tactical training, wear their vest and have their force tools so that they can stay and keep others around them safe. We need to think about creating mental wellness around them the same way. The brain is the most important and we aren't protecting it in the fullest way possible. Research shows that reducing stigma around seeking mental health services increases access[3], and for that reason this perspective must be integrated into the expectations that are set from day one.

[1] Usher, L., Friedhoff, S., Cochran, S. & Pandya, A. (2016). Preparing for the Unimaginable: How Chiefs Can Safeguard Officer Mental Health Before and After Mass Casualty Events. Washington, DC: Office of Community Oriented Policing Services. Retrieved from https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/Preparing-for-the-Unimaginable/Preparing-For-The-Unimaginable.pdf
[2] U.S. Substance Abuse and Mental Health Services Administration (2019). Recovery and recovery support. SAMHSA. https://www.samhsa.gov/find-help/recovery
[3] Satcher, D. (199). Mental Health: A Report of the Surgeon General. Retrieved from: https://profiles.nlm.nih.gov/spotlight/nn/catalog/nlm:nlmuid-101584932X120-doc

Alexa James
Executive Director
NAMI Chicago
Focus Area: Officer Health and Wellness

- Another strategy to normalizing mental health and having the tools to identify challenges is to evaluate officers' mental health before they begin service and throughout their service. This practice becomes part of the job and helps to ensure that all officers are treated equally and can raise challenges in a safe way.[4] However, be mindful that asking on a job application if you have a history of mental health issues is communicating mental health as a deficit or a source of eliminating you from the program. For example, you don't often see a prompt to provide what reasonable accommodations are needed for a mental health condition in an application.
- Early intervention is key to mitigating and preventing long-term mental health conditions.[5] In San Diego one way this is approached is by providing a variety of ways to access mental health services. The police department uses a model of combining their insurance mental health policies, providing department-resourced gap-filling services, and EAP services to meet officers with a variety of treatment options. During pre-service, the mental health resources available to officers should be communicated frequently and without judgement.
- Before critical incidents occur, officers should already be building resiliency and strong positive coping skills. These efforts help officers manage stress and challenges on the job. Examples of building positive coping skills include being intentional with one's time due to the fact that officers are often beholden to the unpredictability of crisis and the Department's scheduling demands, engaging in mindfulness practice, investing in physical health, including exercise, and investing in the maintenance of supportive relationships.[6]
- Another example of setting expectations earlier in an officer's career are to engage officers' support people directly as a Department. This sets the stage for ongoing involvement and creates an expectation that officers have a support network outside of work. This can also be used an opportunity to educate officers support people about what it may look like if someone they care for is hurting, and can create common understanding of what support looks like.

The second recommendation addresses on-the-job supports that are critical to maintaining health and addressing challenges when they arise:

- Law enforcement agencies should utilize and grow peer support programming as a strategy for engaging officers with low-threshold support when needed. Peer support programs have been shown to assist officers in managing work-related stress and build positive relationships with fellow officers.[7] Peer support services should be utilized for all incidents, not just incidents involving a weapon or when shots were fired. The number of peer support trained officers should be sufficient to meet departmental needs, there should be clear job descriptions for those in the program, and training should include how

[4] Mental Health America. Prevention And Early Intervention In Mental Health. Retrieved from: https://www.mhanational.org/issues/prevention-and-early-intervention-mental-health
[5] Need citation
[6] Gilmartin, K. (2002). Emotional Survival for Law Enforcement. Tuscon, AZ: E-S press.; also see: https://vtt.ovc.ojp.gov/tools-for-law-enforcement; Thieleman, K. & Cacciatore, J. (2014).Witness to suffering: Mindfulness and compassion fatigue among traumatic bereavement volunteers and professionals. Journal of Social Work, 1. 34-41.
[7] Digliani, J. A. (2019). Law Enforcement Peer Support Team Manual. Retrieved from https://www.copsalive.com/wp-content/uploads/2019/PSTManualLE8.02019.pdf

to conduct trauma-informed debriefings. Peer support programs can utilize a model of pairing with new officers in a mentoring capacity for the long-term.

- Training for leadership is also necessary as leadership are not only tasked with day-to-day administrative duties but also with ensure the wellness of their reports. A leader who has been trained on effective communication skills coupled with how to identify when a colleague is in crisis will be more prepared to direct to appropriate mental health resources when necessary.
- The tone set during pre-service must continue on the job. Officers should know when the get into the field that stress and anxiety is normal and that accessing mental health care is encouraged. This is a culture shift for most departments and requires more than a written policy. It must be infused in how officers to their job and support their peers and the officers they supervise. Models such as Zero Suicide have been successful in promoting culture change around mental health issues in healthcare settings.[8]
- Law enforcement agencies must ensure that trauma-informed debriefings are conducted consistently and immediately. All officers should be trained in models such as Psychological First Aid, which teaches participants how to respond to someone who has experienced a crisis. The model focuses on providing practical support (safety, food, transportation), showing empathy through active listening, and providing appropriate mental health referrals.[9]

The last recommendation I will make today focuses on systemic changes that law enforcement agencies must address to build a culture of mental wellness:

- Highest among these strategies is to assign responsibility for addressing and maintaining mental wellness to a Chief Wellness Officer. This person should have an organizational psychology or mental health background and should be responsible for auditing all policies from a trauma-informed lens, auditing the impact of the organizational culture/environment on wellness and managing clinicians across the agencies.
- As a law enforcement agency, it is critical that the health coverage provided to officers adequately and robustly cover mental health services. While there are federal and state laws governing mental health parity,[10] agencies must ensure compliance and should use purchasing power to ensure the health insurance they receive covers all levels of mental health treatment in appropriate settings. This type of audit can be conducted by a Chief Wellness Officer in conjunction with a Human Resources representative.
- Law enforcement agencies should make a commitment to transparent policies and protocols throughout all facets of the agency. This should include critical incident protocol, peer support policy, and reentry protocol after critical incidents, among others. A specific quality assurance policy for all programming, including mental health treatment, should be developed and available transparently to all officers.

[8] See resource at: https://zerosuicide.edc.org/
[9] Usher, L., Friedhoff, S., Cochran, S. & Pandya, A. (2016). Preparing for the Unimaginable: How Chiefs Can Safeguard Officer Mental Health Before and After Mass Casualty Events. Washington, DC: Office of Community Oriented Policing Services. Retrieved from https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/Preparing-for-the-Unimaginable/Preparing-For-The-Unimaginable.pdf
[10] Parity citation

Chief Fred J. Farris

Goddard Police Department

Chief Fred Farris began his career in 1990 with the Kansas City, Mo Police Department and served several assignments including Metro Patrol Division, Street Narcotics Unit, North Patrol Division, and the Traffic Enforcement – Motorcycle Unit. In 1995 he moved to the Lenexa, KS Police Department and was promoted to sergeant in 2005. During his time with Lenexa PD he worked Patrol, Traffic Enforcement Unit, Directed Patrol Unit and supervised the Directed Patrol Unit before building and supervising the agency's first Training Unit. He served as Investigations Division supervisor until his retirement in 2017.

Chief Farris served 20 years on the Lenexa Tactical Unit, supervising the team for 10 years and has been the Board of Directors President for the Heartland Tactical Officers Association since 2008. Chief Farris has served on several committees and work groups to include the PERF Taser Policy Guideline committee, the NTOA SWAT Standards committee and NIJ Technical Working Groups on Excited Delirium, SWAT Technology and Equipment, and Tactical Operations Mission Assessment. He is a member of the International Law Enforcement Forum and has been a course developer and instructor for the National Tactical Officers Association and IACP.

Chief Farris and was the author of the Law Enforcement Mutual Aid laws that were passed in Kansas and Missouri and was a member Law Enforcement and Training and Exercise subcommittees as well the Terrorism Early Warning System (KC Fusion Center) Advisory Board for the Mid America Regional Council. He has a Bachelor of Science degree in Criminal Justice Administration from Park University and is a Certified Public Manager from the University of Kansas.

In August of 2017, he was appointed as the Chief of Police for the City of Goddard, KS, a rapidly growing suburb of Wichita. He serves as the Training Committee Chair for the Kansas Association of Chiefs of Police and is on the Board of Directors for the Wichita Area Sexual Assault Center.

Written Testimony
Chief Fred J. Farris
Goddard, KS Police Department
Officer Safety, Health and Wellness

Honorable Commission Members,

I am humbled at the opportunity to speak to you today and applaud each of you for commitment to such a noble and daunting task as directed by President Trump and Attorney General Barr.

I will celebrate 30 years in law enforcement in April and have seen significant peaks and valleys in our profession that were often marked by events such as the Rodney King incident, the 9/11 terror attack, and Fergusson, Mo. Each one of these events led to changes in policy practice and industry standards. In no time in my career has it been more crucial for our Nation's leaders, law enforcement leaders, and the public to have open and honest dialogue on the safety, health and wellness of those men and women who wear the badge each and every day in service to their communities.

I would like to begin my testimony by framing some of the issues you will hear additional testimony on in the next sessions. You will hear statistics, scientific fact, and opinion from many that are much wiser than I. But I would like to give you my observations from the perspective of someone that has risen through the ranks and is now in a position to make policy for my agency and hopefully set an example for those that will follow me. I hope that my testimony will put into perspective the concerns that many of my peers have as you work to prepare your reports.

I began my career in a large city with the Kansas City, Missouri Police Department at the height of the Rodney King incident and trials. Although many miles from where it occurred, I experienced anti-police sentiment, as did most in my profession. This incident marked one of the first that fell victim to the 24-hour news cycle and trial of public opinion as officers from around the nation were lumped into one category. We carried on with our jobs each day and tried to earn the trust and respect of those in our communities but the stress of increased scrutiny, attacks on police, and threats of civil suits weighed on our minds. The evolution of Critical Incident Stress Debriefs and Peer Support Teams had not yet been fully realized so officers dealt with it as best they could. I experienced this type of traumatic stress in 1992 when Sergeant Jim Leach was murdered a short distance from me in the entertainment district of Kansas City. As we worked to save his life, a riot broke out around us with insults and derogatory statements being hurled at us. Following that incident, the usual protocol of a visit to the department psychiatrist to answer the question "are you ready to return to work" was "yes" and that was the end of that discussion. Those were the answers I knew to give based on cop culture and my desire to get back to work. It would be over ten years before I would see how that incident and the lack of proper follow-up would impact me.

In 1995 I moved to the Lenexa, KS Police Department, a mid-sized agency in a suburb of Kansas City. For the next twenty-two years I worked a variety of assignments and saw the

emergence of a movement geared toward the health and wellness of our police officers. Programs were implemented and cultural ideals changed as many agencies realized that a new generation of officers was filling our ranks. They did not handle the stresses of the job quite the same as we did and were a far cry from the "old guys" I was exposed to as a new officer. This generation was more physically fit, more educated, and certainly more inquisitive. They had a much different way of approaching adversity and also felt a much greater compulsion to let everyone know how they felt. I am not implying that this was wrong, but it certainly required law enforcement to have to adjust its approach to safety and wellness. My concern and the concern that I have heard many of my peers express, is that we may have gone a bit too far the other direction. A biproduct of years of experience, seeing tragic incidents and people at the end of their rope, while problematic if not dealt with properly, does in fact get woven into a law enforcement officer's DNA. Those experiences are what increase his or her ability to handle increasingly more difficult situations without turning away and that experience is what allows that new officer of today to train and mold then new officer of tomorrow. My concern is that we have been too focused on purely reacting to physical and mental health, financial wellbeing, and spiritual contentment. These attributes are the hallmark of an officer that has found balance in mind, body and spirit and is likely to have a long and healthy career.

The actions we took in the latter part of the 20th century were certainly a step in the right direction, but it is my opinion that we need to take the next step. In a compelling book, "Left of Bang", written by Patrick Van Horne and Jason A. Riley, the authors chronicle the work in 2007 by US Marine Corps War-Fighting Lab to change the thought process and approach to dangerous situations prior to an attack or "the bang". It focused on trusting instinct, experience, and senses to make sound decisions or actions "pre-bang" or more simply, proactively. The book became a guide for combat soldiers, police officers and even civilians in managing crisis from a position of strength, "pre-bang", instead of from a purely reactionary position or "right of bang". We now have the opportunity to examine what our "bang" is and how to deal with it proactively.

Our next step in the management of our officers' health, safety and wellness needs to move toward the proactive position and I commend the IACP, Office of Justice Programs and COPS Office for their forward thinking on this approach. The Safety and Wellness Symposium has assembled experts, practitioners, and law enforcement executives as we work to find best practices in improving the wellbeing of our officers. We know from empirical data that I'm sure you will hear testimony on, that so many of the issues our officers face directly impacts the operations of our organizations. Stress and sleep patterns are often directly tied to use of force complaints, accident data and job performance. Financial insecurity often leads to marriage stress that can affect attitude and performance at work, poor decision making, lead to criminal behavior, and even depression. Imbalance in one's personal life can lead to ethical issues that may cross between on and off the job. From my perspective, many, if not all these issues can be addressed "left of bang". We as administrators, working independently or with the help of local partners, grants, or federal assistance, can begin to change the culture in our profession and work proactively rather than reactively.

In my organization, for example, the leadership team has worked the last year and a half at my direction, to begin implementing programs and initiatives that will address many of these issues. We have an understanding that what works for one will not work for all and that having

multiple options are key to gaining buy-in from the troops. I implemented a mandatory annual mental health "check-up" and partnered with a local phycologist for one hour of paid time per year with each employee to include the chief. This is not a testing session or an evaluation but simply time for each officer to unpack some of their baggage and discuss anything that is on their mind. There were concerns that some officers would push back on being required to go but in my mind it was a risk worth taking if even one officer, that has maybe wanted to seek help but didn't out of concern for being stigmatized, now had a chief's mandate as an excuse to open that door. According to Blue HELP, at least 228 police officers took their own lives in 2019. In how many of those cases were signals present or did we have an opportunity to intervene? We are aware of this crisis more than any time in my career. It is not only OK to talk about it but high time we did something to remove that stigma that if you ask for help, you are somehow weak.

We have brought in partners to discuss financial planning with employees and their spouses and are currently working with our local bar association to solicit pro-bono legal assistance in preparing wills, trusts, and power of attorney for officers and their spouses to better prepare them for financial success or in the event a tragedy should strike. We have fostered a grass roots effort to increase physical fitness and implement a wellness policy at the request of line officers. And we have established a chaplaincy program for use in the traditional sense as well as giving the officers one additional resource in their time of personal need.

I am aware that some of these initiatives take funding, funding that may not always be available to smaller or rural agencies. I am fortunate that my budget supports it and my officers have embraced it. That is not always the case and there exists an opportunity for this commission to help by supporting plans and practices that look to build the whole officer. Encouraging partnerships with existing governmental entities and community organizations is key to increasing awareness and encouraging solutions. When officers are healthy, well cared for, and happy, the organization benefits in recruitment and retention. The community benefits from having levelheaded professionals patrolling their streets. And our profession benefits from decreasing the number of incidents that gain the public spotlight by hopefully catching or preventing those influences in mind, body and spirit that can cause the next tidal wave of national scrutiny.

This commission has the daunting task of sifting through the vast amount of information you will receive from the fifteen working groups. I hope that you will consider the fact that the foundation for our profession is each officer that puts on their uniform each day. If we can find ways to better care for them, many of these other issues may self-correct.

Thank you again for your time and the opportunity to appear before you.

Scott S. Coyne, M.D.

Suffolk County Police Department

Dr. Scott Coyne has served as the Chief Police Surgeon and Medical Director of Suffolk County Police Department since 1992, and in addition to other responsibilities, he oversees the Police Academy Emergency Medical Training section and all field emergency medical operations. He has strongly supported and enhanced the EMT training program for SCPD police officers, integrating an active program of combat medical care training. Twelve (12) years ago he initiated the Medical Crisis Action Team (MEDCAT) program, a type of 'medical swat team' now composed of 30 officers from different commands who continually train in ALS, combat care and strategic operations, and are certified as Paramedics or at the similar Critical Care-EMT level. Dr. Coyne was named the 2016 New York State EMS Physician of Excellence, and in 2017 the MEDCAT team received the prestigious Officer Safety Award from the National Law Enforcement Officers Memorial Fund – US Department of Justice Valor Program.

Dr. Coyne is a graduate of SUNY Downstate College of Medicine, and completed his internship and residency at the Medical College of Virginia in Richmond, where he also served on the faculty, before returning to his home on Long Island. For 25 years he served on the medical staffs at a number of large hospitals in the New York metropolitan area, ultimately becoming Department Chairman at several of them.

Dr Coyne is a former police officer and was the first physician on scene at the Avianca commercial jetliner crash in 1990, several miles from his home. He received many awards for establishing triage and treating dozens of victims at that disaster, and credits that experience and his background as the reasons for his focus on development of these law enforcement emergency medical programs. He actively continues teaching and has trained thousands of police officers, EMS and fire rescue personnel, particularly over the past 10 years. He currently holds a faculty appointment in Emergency Medicine at SUNY Stony Brook University School of Medicine.

Medical Training for Police Officers To Save The Lives of Citizens and Fellow Officers

Scott S. Coyne, M.D., Chief Surgeon, Medical Director, Suffolk County Police Department

The events of 9/11, the ever increasing active shooter incidents in our country and targeted attacks on police officers have changed the world of law-enforcement. In response to these high profile events unique tactical law enforcement training has been implemented. Because these scenes are deemed highly unsafe because of the possibility of other shooters or secondary devices, EMS may not be able to safely respond to provide care. Therefore, law enforcement may be the only resource to provide initial lifesaving medical care to victims in these mass casualty situations. The LEO needs every possible tool for their protection and safety, particularly if targeted and wounded by an assailant, during which the LEO must be able to provide immediate self-care, or may need a partner to provide care.

Military combat injuries in Vietnam, Afghanistan and Iraq have been carefully analyzed, and have clearly identified the most common causes of death on the battlefield. The results were consistent and incontrovertible and have been corroborated by federal agencies, joint task forces, the Committee on Tactical Combat Care, and most recently described in The Hartford Consensus. Hemorrhage was and continues to be the primary cause of preventable death in ballistic trauma victims. 20 years ago the Defense Department reversed policy, identifying the need to aggressively address hemorrhage control and to '*begin care at the point of wounding*'. Hemorrhage control is crucial, as are airway management and sealing a 'sucking chest wound' to prevent a tension pneumothorax. Military service members now receive combat medical training and are issued tourniquets and other equipment. This effort has resulted in an astounding decrease in battlefield mortality, which some estimate at a 70% reduction.

In the Civilian Setting The Law Enforcement Officer is the Tactical Medic in the initial phases - Although some law enforcement agencies embed civilian medics in their tactical teams, such teams are generally not present during the initial phase of an incident. The primary responsibility for providing medical care following threat containment - during the short window of opportunity to save lives- falls on law enforcement officers. As these situations may remain 'unsafe' for potentially long periods, during the active phase the LEO typically is the only source of emergency care for victims with life-threatening injuries. After addressing the threat, the LEO must immediately transition to victim care. We emphasize to our officers that in these situations they are "the Tactical Medics" who must be well versed in giving Care under Fire (CUF) with a clear understanding of the procedures for transitioning care to EMS, and the ultimate goal of ambulance transport to the hospital for definitive medical care. Exsanguination from a major arterial laceration occurs in a matter of minutes and is the most common cause of preventable death. Less commonly, there could be blast trauma such as occurred at the Boston Marathon which resulted in massive hemorrhage and extremity amputation. Commercial tourniquets which are very effective for extremity hemorrhage were unavailable, so the police and other first responders fashioned makeshift tourniquets, which unfortunately have been shown to be frequently ineffective to control bleeding. Some police agencies have implemented trauma kits with a tourniquet, airway device, and chest seal to treat a sucking chest wound.

There is no substitute for the LEO as the primary medical provider in these situations. Since 2011 our officers are trained in rapid deployment, the primary mission of threat suppression, and the rapid transition to victim care. As you know, the numbers of victims vary widely from 10 or 12, to 72 at the Century Aurora shooting, to more than 450 at the Las Vegas 2017 Harvest Festival.

On the 'battlefields' of Main Street USA, the trauma from ballistic injuries are the same as the military battlefield, with virtually identical causes of preventable death, bleeding, chest trauma and airway compromise. To assure officer safety and chance for survival, every LEO must be trained in tactical combat medical care, 'Care Under Fire', balancing the tactical engagement of the threat and providing medical care, and must receive the proper equipment. In addition to medical care, training must include rapid victim triage, methods of victim extraction, formation of force protection teams, selecting a casualty collection point, common terminology and Unified Command structure. We all know the stories of these incidents. They occur each week, gain media attention, and alarm law enforcement organizations, government agencies and elected officials. But just as the Pentagon did, it is up to law enforcement leadership to provide every officer with the training and vital equipment for self-survival and treatment of casualties.

These situations are highly chaotic, and an effective Command-And-Control structure is one of the most critical components to assure a successful outcome, allowing rapid transfer of victims from law enforcement to EMS and ambulance transport to the hospital. Careful preplanning and coordination with EMS and fire/rescue agencies, implementation of a well-developed *Unified Command* structure, and coordination of radio communications are essential. Cross training with EMS and fire/rescue personnel, as our department has undertaken, is crucial to accomplish this coordination. *Time Is Not On Our Side* in these situations. Rapid care very frequently determines victim outcome and survival.

There is no alternative or substitute for this emergency medical care by law enforcement, which requires ongoing training for proficiency. The good news is that this critical training can be accomplished in 4-6 hours, and the equipment is relatively inexpensive. A commercial tourniquet, the mainstay and most critical piece of equipment, costs about $30. Some agencies issue small trauma kits containing a Tourniquet, Quick Clot, chest seal, gloves and airway- cost is about $100. A general recommendation for a training program may include selecting an officer with EMT or paramedic certification to assist in coordination the program, and also might include train-the-trainer education. For smaller departments, collaboration with adjacent departments for medical equipment purchase and joint training are reasonable considerations.

In 1989 SCPD began training and certifying every police recruit as a New York State EMT. Currently the majority (1300) of our officers maintain EMT certification. The department and the county invest in this program because they recognize that nearly 1/3 of our emergency calls are medical/trauma related. Officers are most frequently on scene first during the critical window of opportunity prior to arrival of EMS. While most calls don't require acute medical care by our officers, other situations need critical care within minutes. It is during these initial 'Golden Minutes' that our officers have saved thousands of lives from cardiac arrest, obstructed airway, severe bleeding, and other life-threatening conditions. For instance, our police officers

have administered Narcan to nearly 1400 victims of opiate overdose, with a 98% success rate. Our program has served as a national model for law enforcement Narcan programs. Our police officers have established excellent relationships, working hand-in-hand with responding EMS, fire and rescue. While I do not submit that every police officer should be an EMT, I do hold that every officer must be trained and have equipment to provide lifesaving medical care to the people they serve and protect.

12 years ago SCPD created the Medical Crisis Action Team (MEDCAT), composed of police officers with paramedic or EMT-Critical Care ALS certifications. The team has grown to 30 officers from precincts, marine bureau, Academy, highway patrol, detective and headquarters staff. Although the initial mission was response to tactical situations such as active shooter, day-to-day MEDCAT also responds to serious calls, MVAs, cardiac arrests, overdoses, and barricades when weapons or hostages are involved. The team trains monthly in ALS skills, tactical medical care and strategic operations. MEDCAT received the 2017 General Officer Safety Award from the National Law Enforcement Memorial Fund and DOJ Valor Program.

I would like to describe 2 dramatic situations during the last several years in which our officers saved fellow officers with life-threatening conditions during the Golden Minutes. The first officer sustained a severe head injury after intentionally being struck by a fleeing SUV. MEDCAT officers recognized severe neurologic injury and decided to transport by helicopter to a level I trauma center rather than to the local hospital. MEDCAT officers triaged, maintained the airway, supported respirations and began intravenous fluids providing critical lifesaving prehospital medical support. One MEDCAT officer ventilated the patient during helicopter transport accompanied by the flight medic. His brain injuries were extensive and typically carry a 50% mortality. Without this initial care I do not believe he would have survived, or if he did, would have probably lived with severe chronic disability. Following hospitalization and a long head injury rehabilitation, he miraculously returned to full duty as a detective one year later and remains active in our criminal intelligence section.

A 2nd case occurred only 3 ½ weeks ago when a police officer collapsed during an investigation. The 2 officers with him immediately confirmed cardiac arrest and began effective CPR, retrieved an AED, and delivered 2 shocks for continuing cardiac arrest. MEDCAT officers arrived, and with arriving EMS established an IV, administered medications and repeated cardiac shocks. As they carried him toward the ambulance he began to move and had return of heart function prior to hospital arrival. Within the hour I arrived at the hospital where he immediately recognized me, was fully coherent and alert. After undergoing cardiac procedures he returned home last week where he is recuperating and resting comfortably.

It is eminently clear not only to law-enforcement leadership and officers, but to the public as well, that the need for rapid delivery of emergency medical care by police officers at life-threatening medical and traumatic events is an undeniable reality, and is also a fiduciary duty which must be embraced.

William R. King, Ph.D.

Boise State University

William R. King, Ph.D. is a Professor of Criminal Justice at Boise State University. He earned his Masters and Ph.D. in Criminal Justice from the University of Cincinnati in 1994 and 1998, and his Bachelor's degree in Criminal Justice from UMASS at Lowell in 1992. He served as a Professor and Associate Dean of Research in the College of Criminal Justice at Sam Houston State University (SHSU) in Texas from 2009 to 2019.

While at SHSU he established an ongoing study of Texas Police Chiefs, in conjunction with the Law Enforcement Management Institute of Texas. The study (called TCPPP) has surveyed more than 1100 chiefs multiple times, and is soon to start its fifth wave of data collection. A major focus of TCPPP was studying health and wellbeing among Texas chiefs. In 2018 Dr. King conducted a national survey of 741 police chiefs, with the assistance of IACP's State Association of Chiefs of Police (SACOP) and the SafeShield committee. His testimony today is based upon findings from the Texas chiefs and the national study of chiefs.

William R. King, Ph.D., Professor of Criminal Justice. Boise State University.
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Police officer health and wellness (specifically, stress, burnout, job satisfaction, and turnover among police chiefs and their employees).

The problem: Prior scientific studies of police officers have clearly established the health and wellness problems caused by high stress and burnout, including decreased job performance, metabolic syndrome, suicidal thoughts and behaviors, and depression among others (see Violanti et al. 2017). As one example, a recent study of the life expectancy of police officers revealed that, on average, police officers live 21.9 fewer years than members of the general population (Violanti et al. 2013). Put simply, the occupation of policing is killing its own, in many cases slowly and in some instances suddenly.

The role of leadership: Police chiefs (for brevity, I use police chiefs, although my statements should be applied to sheriffs, constables, marshals, and the commanders of state police agencies) also cope with stress, burnout, turnover, and low job satisfaction themselves. Two recent studies of health and wellbeing conducted with police chiefs, one involving 916 Texas chiefs, the other a national study of 731 chiefs, reveal that chiefs experience moderate to high levels of stress and burnout (see Brady and King 2018, 2019; Brady, King, and Jurek 2019). Furthermore, chiefs reporting greater levels of burnout and greater conflict between work and family were more likely to report they were seeking to resign as chief, retire early, or quit outright. Estimates vary, but the average tenure of a police chief is only between 5 and 7.3 years. Early turnover of chiefs impedes the effective operation of policing agencies and our ability to address health and wellness among police officers (or deputies and troopers). Like an insidious virus, the very problems we seek to address (burnout, stress, etc.) also harm our ability to identify possible solutions as they push chiefs to step-down and leave policing.

Additionally, police chiefs often work in isolation, without the support or counsel of other employees, a situation that only exacerbates their stress and burnout. Culturally, chiefs are expected to be strong and confident leaders who lead, manage, and attend to their employees' wellbeing. But, the wellbeing of chiefs is often left to chance. Many are challenged by the considerable responsibilities and new roles imposed by the position. Many also will not confide-in or seek advice from subordinates. It is lonely at the top, and stressful and unhealthy too.

Most police agencies are very small. There are more than 18,000 police agencies in the US, which complicates any effort to combat the problem of officer health and wellness. Most of these agencies are very small; 49.5 percent of local agencies employ less than 10 full time sworn officers, and 88.3 percent of local agencies employ less than 100 full time sworn officers (Reaves 2010). Smaller agencies have limited access to resources for employee wellbeing, such as community-based counselors and mental health services. Organizationally, they lack the structure to create or improve an employee assistance program (EAP), or to even assign an employee to oversee health and safety. Any proposed remedy for officer health and wellness must be readily accessible to employees in small agencies, must be deliverable in rural and small communities, and must work in areas with little community health and wellness resources. In other words, programs and solutions implemented by large police agencies may not scale

downward and work for small agencies. Additionally, possible remedies should also target chiefs specifically, given their isolation.

Solutions come at the agency level: Improving policing and solving its problems are most often addressed at the agency level due to local control of policing agencies. For example, policing has improved by its own initiative with the adoption of model policies and administrative rule making at the agency level. Federal resources directed towards addressing police health and wellness will have to flow into agencies and the solutions will be implemented by thousands of individual agencies.

Chiefs as the key: The implementation of any **s**olutions depends on the buy-in of the chief. The effective solution involves first targeting chiefs with health and wellness interventions. If we can show chiefs the intervention improved their health and wellbeing, they are more likely to advocate for the intervention with their employees and let it diffuse through their agency. Of course, helping chiefs is important in its own right, but they also serve as the key to implementing interventions at the agency level.

There are no single, simple solutions: Health and wellness interventions for police come in a myriad of types and approaches. Focusing just on stress management interventions, some solutions seek to remove the sources of the stress, a second group attempts to protect people from developing high levels of stress, and a third class attempts to lower extremely high levels of stress. A recent summary listed numerous techniques used to decrease stress in police employees, including, "spot checking and scanning, positive self-talk, deep breathing, anchoring, cognitive rehearsal and desensitization, progressive muscle relaxation, meditation, imagery and biofeedback, goal setting, stress debriefing, time management, financial planning, visual-motor behavior rehearsal (VMBR), critical incident stress management (CISM), physical fitness, progressive relaxation, biofeedback, social support, eye movement desensitization and reprocessing (EMDR)" (Patterson 2014: 491-2). A broader review of stress programs for other occupations adds yoga, writing and journaling, mindfulness, body scanning, and nutrition, among others to the list.

Is it really this complicated? Yes. If these were simple problems, the solutions would have been discovered and implemented years ago. The problem of officer wellness and health is complicated. The causes are multiple and latent, have differential impacts upon people depending upon their attributes and work conditions, and the effects are differential as well. Add in the complexity of multiple interventions, providing different levels of dosage and fidelity of treatment, tried with different groups of police employees (and studies using non-police as subjects) and the product is a multi-layered, complicated tableau.

What do reviews of police stress interventions show? As one example of the complicated nature of police wellness, we can look at three systematic reviews of the police stress literature. Webster (2013) and Penalba et al (2009) found the pre-existing studies of police stress (Webster) or stress reduction techniques (Penalba) were too diverse and scattered to allow conclusions about the causes, or best remedies to police stress. A more recent meta-analysis of 12 scientifically rigorous studies of intervention programs and police stress (Patterson et al 2014)

found that intervention programs did not significantly decrease stress, although the overall trend in stress was downward. Our desire to determine what works is impeded by the limited number of studies of police employees coupled with the weak methodologies used by some studies. It is likely that some interventions are effective, but we must rigorously evaluate them to know for sure.

Proposed interventions must be rigorously evaluated by researchers. Police officer health and wellness was identified as one of the six pillars in *The President's Task Force on 21st Century Policing* (2015). Health is one of the 15 working groups of *The Presidents Commission on Law Enforcement and the Administration of Justice* (2020). Officer health and wellbeing are problems worthy of our effort and money. No doubt, a range of well-meaning advocates will rush forth with stories and anecdotes detailing the successes of their programs or interventions with hopes of spreading them to police agencies. These interventions must be rigorously evaluated using samples of police employees. The evaluations should use scientifically strong research designs, such as random assignment of participants to experimental and control groups, and checks that interventions will have the same outcomes across the various types of agencies, locations, officers, and assignments. Similarly, studies should employ established methods such as pre-tests of participants and long-term follow-up to determine the rate at which benefits decrease over time.

Conclusion. Interventions must target police chiefs and must work for small agencies. Chiefs are often overlooked by interventions that target officers. Health and wellness interventions target chiefs directly and evaluate the effectiveness of the interventions. Interventions that work for chiefs can be quickly translated into interventions for officers that do not rely on resources, personnel, or structures that small agencies lack such as specialists in residence, staff counselors, EAPs, or community resources.

Alexander L. Eastman, MD MPH, FACS, FAEMS

Dallas, Texas, Police Department

Dr. Eastman is the Senior Medical Officer at the Department of Homeland Security's (DHS) Countering Weapons of Mass Destruction Office (CWMD). In this role, he is responsible for operational medicine across DHS in addition to countering threats to the United States worldwide.

Dr. Eastman is a Task Force Officer with ICE Homeland Security Investigations and is assigned to the Special Response Team (SRT) program. Dr. Eastman is also a Dallas Police Department lieutenant, the Chief Medical Officer of the Dallas Police Department, and the Lead Medical Officer for the Dallas Police SWAT Team. He is actively involved in national planning for law enforcement medical support through the Department of Justice's Officer Safety and Wellness Group, the Committee on Tactical Emergency Casualty Care, the Hartford Consensus Working Group and serves as the Medical Advisor for the Major Cities Chiefs Association.

Dr. Eastman was recently awarded the Dallas Police Department Medal of Valor for actions taken during the July 7, 2016 police ambush and has been previously honored as an Outstanding Young Alumni (2014) from The University of Texas at Austin, the Joe C. Jones Reserve Officer of the Year (2013) and Officer of the Year (2014) from the Dallas Police Department and Dallas Police Association.

Formerly, Dr. Eastman served as the Chief of the Rees-Jones Trauma Center at Parkland Memorial Hospital in Dallas, TX. He was also an Assistant Professor and trauma surgeon in the Division of Burns, Trauma and Critical Care at the University of Texas Southwestern Medical Center and continues to be a practicing trauma surgeon.

A graduate with distinction of the George Washington University School of Medicine, he completed his general surgery and two fellowships at the University of Texas Southwestern Medical School/Parkland Memorial Hospital. He is board-certified in General Surgery, Surgical Critical Care, and Emergency Medical Services. Dr. Eastman also has a Master's Degree in Public Health from The University of Texas Health Science Center--Houston.

Written Testimony of
Lieutenant Alexander L. Eastman, MD, MPH, FACS, FAEMS

Chief Medical Officer
Dallas Police Department

Before The President's Commission on Law Enforcement and the Administration of Justice

February 27, 2020
Miami, FL

Chairman Keith, Vice-Chair Sullivan and distinguished members of the President's Commission on Law Enforcement and the Administration of Justice, thank you for the invitation and opportunity to present my perspective on officer safety in the 21st century. Notably, it's nearly five years to the day since similar testimony in Washington DC. It is my sincere hope that we've made this profession and this country safer since then, though there is certainly no shortage of additional work to accomplish. By my unique background, I hope I'll be able to compel you to action this morning.

Background

Currently, I serve as a Dallas Police Department lieutenant, assigned to our SWAT Unit as its lead medical officer and the Chief Medical Officer for the entire Dallas Police Department (DPD). In this role, I am both a law enforcement officer and a physician. It is the nexus of these two unique but intertwined roles that allows me to speak comfortably today on officer safety and wellness. Many of the issues faced by law enforcement in the United States today have either a public health or a medical nexus. Over the past nearly 16 years, my office has advised or implemented programs from ranging from operational medicine to responding to emerging infectious diseases, from self-aid buddy-aid to law enforcement suicide prevention programs. In short, no task is too large or small and in short, the CMO serves to advise and support the Chief of Police on all health matters that might affect the Dallas Police Department.

In addition to this role, I serve at the federal level as well. However, I am also a practicing trauma surgeon and surgical intensivist. Until a relatively recent job change, I was the Chief of Trauma at the Rees-Jones Trauma Center at Parkland Hospital. It is there that I learned how to truly be a surgeon and physician, to care for all in their most desperate hour and how to lead a team of very Type-A individuals motivated behind the common goal of serving their community and making that community as safe as possible. It is this skill set that I try to bring to bear each day, no matter the uniform I am wearing at the time.

Over the last 16 years, the unique intersection of trauma surgery, public health and law enforcement has been my life, with the near singular focus of not only making improvements to the safety of LEOs but also improving the overall safety of our communities as well.

Stop The Bleed: A Critical Law Enforcement Skill

As a proud plank holder in both the Hartford Consensus and the StopTheBleed movement, hemorrhage control programs in law enforcement agencies have become commonplace. This explosion over the last decade represents a true paradigm shift in the way LEOs think and act when standing before someone injured. At their foundation, law enforcement hemorrhage control programs remain based in the hard-learned lessons from battlefield injuries, however as our own experience has matured, so has our ability to demonstrate the effectiveness and potency of a well-trained and well-equipped police force in saving lives in their communities and nationwide. While policing remains inherently dangerous, preventable deaths from unchecked bleeding in our communities continues to fall. We, as law enforcement professionals, should do our part to join physicians, researchers and public health professionals in striving to eliminate all preventable deaths from our communities.

Law enforcement hemorrhage control programs save lives. The Dallas Police Department has had a comprehensive, department-wide hemorrhage control program since 2013. DPDs Downed Officer Kit program issues each member of the Department, both sworn and civilian, a kit containing a SOFT-W tourniquet, an Olaes modular bandage and a roll of Quikclot Combat Gauze, a hemostatic agent. These kits have proven invaluable, not just saving more than ten of our own officers but have been used to save more than 50 civilians as well. While I'd like to hail these results as unique, they have become common place among law enforcement agencies across the United States. At last check, approximately 18 month ago, more than 85% of the agencies that make up the Major Cities Chiefs Association had instituted similar programs—all with similar results.

Many have called these hemorrhage control programs the ultimate community policing program—training and equipping police officer to save lives in their community. I would encourage any remaining departments without organized programs to please reach out to us and let the Dallas Police Department help you get started.

StopTheBleed: Not Just for LEOs Anymore

Originally spawned from high profile active shooter events and the Boston Marathon Bombing, several law enforcement organizations including the Federal Bureau of Investigation and the Major Cities Chiefs Association are foundational members of the movement known as StopTheBleed. In just over five years, led by the American College of Surgeons and joined by several other large medical and professional organizations, StopTheBleed has become commonplace in communities all over the United States and the world. To date, nearly 75,000 instructors have trained more than 1.4 million people in the same hemorrhage control techniques we taught our nation's law enforcement officers. While many view this accomplishment as laudable, there is more work to be done. In a country of more than 300 million people, we must continue to expand StopTheBleed into more places and train more Americans. In fact, in the most progressive jurisdictions in the country, police departments are partnering with healthcare and other first responder organizations to teach StopTheBleed in their communities.

A Continuing Need for Data: LEO Injuries

In testimony before President Obama's Task Force on 21st Century Policing, four years ago, I discussed the difficulty in tracking law enforcement injuries. From the public health approach, we've learned that the key to being able to intervene on a problem is to first be able to measure that problem. While there has been considerable progress at revising the Law Enforcement Officers Killed and Assaulted (LEOKA) data set, it still lacks the granular medical information that would be required to study this topic in appropriate detail. Law enforcement, to make meaningful improvements based on the science of law enforcement officer injuries, must find a way to capture comprehensive

injury-based data for our members at the national level. Unfortunately, despite valiant attempts, neither workman's compensation data nor an expansion of LEOKA seems to have given us what we need. A novel solution, easy to use and easy to study, must be crafted to give us the information we need to create LEO safety programs directed towards the injuries that are hurting our members.

It's OK Not to BE OK

Writing this testimony, I'm in my office surrounded by the memories of hundreds of incidents over the last 16 years. There are critical incidents, dangerous incidents, comical incidents and incidents in which friends and teammates have not made it home. The morning after our July 7th ambush attack, I walked back into my house and it was eerily silent, the first silence I'd heard since the attack began. Everyone was sleeping peacefully, including my yellow Labrador. Yet I felt I needed to see my son, sleeping soundly in his crib. That's where I cried the first time of many. I knew then that I'd be talking about the law enforcement response to this critical incident and others for a long time to come. Right then I made a commitment to myself, my brothers and my profession. We must recognize the toll that a lifetime of incidents like this leave on us and our families, both blue and blood. There will be many others who testify to this topic in the coming hours, days and months, but it has become apparent that the psychological effects of policing represent at least as great a risk of death, injury and long-term disability, than any other more traditional form of trauma. While I've spent the better part of the last 16 years focused on trauma and hemorrhage, it has become clear that this is merely one pillar of a comprehensive officer safety and wellness program. We must continue to develop, strive to understand the often-intangible effects of a career in policing and ensure that programs are available to protect our personnel at all times.

Recommendations

In summary, I would offer The President's Commission on Law Enforcement and the Administration on Justice the following recommendations:

1) Ensure that hemorrhage control training and the provision of hemorrhage control equipment is required at every U.S. law enforcement agency.
2) Encourage law enforcement agencies to partner with community healthcare and first responder organizations to expand StopTheBleed training nationally.
3) Implement a national, comprehensive database for law enforcement officer injuries and treatment.
4) Ensure that every law enforcement agency nationwide has a robust peer support program focused on countering the psychological effects of repeated exposures to critical incidents.

Conclusions

Serving my community, our country and this great profession has motivated me through many difficult and challenging times throughout my professional life. While I look at the great progress that has been made over the years in integrating the two communities in which I serve, it remains clear that much work remains. The nexus of law enforcement, trauma care, public health and officer wellness is one that is unique and challenging. Yet, as we continue to work to improve officer safety and wellness together, it is partnerships like I've described and those yet to be developed that will make us all successful. I am humbled by the opportunity to speak before you today and look forward to the day in the future that hearings such as this one will be obsolete. My thanks to Chairman Keith, Vice-Chair Sullivan and each of you for your time.

Acknowledgements

My sincere thanks to Chief U. Renee Hall, Chief David Brown, Chief David Pughes and Chief David Kunkle for all their support. And to my partners and teammates who make each day possible, you are why I do what I do.

Officer Nicole Juday

Indianapolis, Indiana, Police Department

Officer Nicole Juday is a 13 year veteran of the Indianapolis Metro Police Department (IMPD) currently serving as Developmental Programs Coordinator for the Office of Professional Development and Wellness at IMPD. Nicole is responsible for the day to day managing of the IMPD Mentoring program which involves over 175 formally trained Mentors assigned to Recruit and Veteran officers to assist officers in addressing personal and professional challenges. Nicole has previously worked as an undercover narcotics investigator. She is currently on staff for the IMPD's regionally recognized Leadership Academy and serves as a member of the Curriculum Committee. Nicole is a subject matter expert on wellness and police mentoring for the International Association of Chiefs of Police. Additionally, she has served as a national delegate to the Department of Justice and Bureau of Justice Assistance/COPS Officer Safety and Wellness Working Group. Finally, Officer Juday assisted in managing the BJA/COPS grant awarded to IMPD as part of the Officer Safety and Wellness Pillar of the President's Task Force on 21st Century Policing. Nicole is a graduate of Butler University (IN) with a degree in Sociology and Criminology.

Officer Nicole Juday
Office of Professional Development and Wellness/Mentoring
Indianapolis Metropolitan Police Department (IMPD)
Focus Area: IMPD Wellness Unit
Topics: Confidentiality, Funding & Referral Resources, IMPD Best Practices

In 2010 the Indianapolis Metropolitan Police Department (IMPD) formally implemented what is known as the Office of Professional Development and Wellness (OPDW). The unit's creation was spearheaded by a Captain who reviewed disciplinary action for the agency. He began to see a pattern of normally high performing officers failing in the performance of their duties. He started meeting with these officers to identify why their performance at work had become substandard. It was at this juncture that the IMPD philosophy on officer wellness began shifting from one of reactivity to one of proactivity. The Captain realized, as a result of his interpersonal meetings, that the officer's problems were cyclical; they were struggling at work due to stressors at home and struggling at home because of stressors at work. Today, the IMPD OPDW is recognized as being one of the model wellness units in the country. The successful paradigm shift has been supported by external factors such as state law being enacted to protect confidentiality, effective referral resources and funding from both internal and external sources; and, after ten years of mindful collaboration between the officers of the IMPD, the members of the OPDW and the administration, wellness is an accepted part of the organizational culture. Officer Wellness is now formally and informally entrenched in every aspect of an IMPD officers career: it begins through introduction to a formally assigned mentor the first week of the academy, continues throughout their career and culminates by walking the officer through the retirement process with someone from the OPDW.

Confidentiality is the cornerstone to a successful officer wellness program. The OPDW operated for seven years without lawful protection of confidentiality but in 2017 the Governor of Indiana, Eric Holcomb, signed House Enrolled Act 1122.[i] This bill allows officers trained in Critical Incident Stress Management (CISM), and operating in the capacity of peer support, the freedom from civil, criminal and or administrative subpoenas or hearings. Officers learned to trust members of the OPDW prior to House Enrolled Act 1122 being signed, but it has helped greatly in the instances where officers are more reluctant to ask for help or share information. In 2019, 70% of the officers that OPDW worked with voluntarily asked for help or were referred by a peer. It could be argued that part of the continuation of the cultural shift in Indianapolis can be attributed to the safety that this law creates between officers and peer supporters. Unfortunately, there are significant differences in approach and legislation from state to state on this topic; there are states who do simply do not afford their officers, or peer support members, the same protection.

Successful officer wellness programs need access to culturally competent resources. This access comes through relationship building by peer support units and funding from both internal and external resources. The OPDW, which now consists of five full-time sworn officers, serve the 1700 men and women of the IMPD as well as nearly 200 civilian employees and their collective families. All individuals who currently work in the office are sworn police officers and assist in assessing needs and directing people to appropriate resources. The vetting process to finding proper care is costly and time consuming, but absolutely imperative to the positive

functionality of a police wellness unit. The members of the OPDW are collectors of resources not exclusively within Indianapolis, but statewide as well as nationally. Referral resources need to be diverse and holistic; what is effective for one officer may not be effective for another. The OPDW aligns resources with the five main areas where officers frequently fail. These areas include: addictive issues, mental health, physical health, personality disorders and in their interpersonal relationships. Resources should be holistic and exist in whatever capacity an officer needs. There still exist agencies across the country that offer *zero* mental health coverage to their officers. The singular, and culturally devastating, message this sends to officers is obvious: mental health is not important. A study done in 2001 showed "Police officers experience, on average, three traumatic incidents for every six months of service."[ii] Preventative care is an absolutely crucial component to the healthy maintenance of an officer's career solely based on trauma exposure.

It is the view of the IMPD, and the OPDW to pursue its people. The OPDW has two main responsibilities– officer development and crisis response. The philosophy is that if OPDW focuses on developing officers through education that ultimately crisis response lessens. Members of OPDW have offered multiple department-wide trainings about early warning signs of crisis, trauma, resiliency, dietary issues, mentoring and a multitude of other topics. The IMPD Mentoring Program pairs recruits with a mentor within the first week of the academy. All mentors complete three days of formal training offered by IMPD OPDW. The program currently consists of approximately 175 mentors; all of which are part of the program on a voluntary basis and do not receive any extra compensation for their time and efforts. Currently, the IMPD, which runs its own training academy for new recruits, is hiring an average of 140 new officers per year. Mentoring has proven to be successful in areas of mistake avoidance, cultural assimilation and most importantly normalizing a recruit to talking about, not suppressing, everyday stressors. Ultimately, the goal is that encouraging communication early in one's career normalizes the long term sustainability of the officer talking about their stress. It is currently estimated that in Indianapolis it costs $125,000 to train and equip a recruit. Mentoring has proven to be successful in the retention of high performing recruits who have just simply needed a bit more guidance and help adjusting to their new role in policing. It is safe to say that mentoring at the IMPD has become a fundamental component to officer health and wellbeing.

Another component to IMPD OPDW is crisis response. Members of the OPDW receive referrals of officers in need from multiple sources which include peers, the chaplain's office, Internal Affairs and Special Investigations, supervisors and family members. Indianapolis has also implemented specific protocols after critical incidents/officer involved shootings. The structure of the process has proven to relieve stress for officers. The Peer Officer Support Team (POST), a group of roughly thirty volunteers divided into three teams of ten rapidly responds on the scene immediately following an incident. Each team is on call for one month at a time. Whichever team is on call will respond to the scene. Their rapid response serves as the beginning of the wellness process. After the scene is released the assigned POST member stays in contact with the officer(s) involved until a member of the OPDW has made contact with the officer(s). Contact is made by one of the five members from OPDW within 24-48 hours after the critical incident. During this time a meeting with the officer, and his or her support system, is scheduled. Following the initial meeting with OPDW the officer has one mandated visit to the Employee Assistance Program (EAP) where they see one of four counselors who have been specifically

vetted to work with first responders. It should be noted that the Internal Affairs (IA) investigation is occurring simultaneously to the officer moving through the OPDW process. After completion of the internal affairs interview, they are scheduled for a critical incident debriefing with an IMPD contracted psychologist; IMPD no longer uses fitness for duty evaluations post-critical incident. Following clearance from the psychologist, the officer returns to work in a limited duty capacity. The officer remains working in a limited duty capacity until approval from The Executive Review Board to return to full duty is obtained. Currently, the process takes an average of two weeks. There are other ways that the OPDW pursues its officers as well. The Wounded Guardian Program exists to recognize those officers who are ill or injured and have become separated from the agency due to medical leave and assist them in fulfilling needs that have occurred as a result of their illness/injuries. Volunteers have helped in a numerous way that range from planting trees and yard work, grocery shopping, providing transportation to medical appointments and even delivering furniture. The office also receives a daily report of any high profile incidents that may have occurred on each of the cities six service districts. OPDW reviews this report and contacts all officers involved and encourages officers to meet and talk about the incident. Touching base in this capacity also plants a seed for future communication and opens a door for discussion about other potential life stressors not specific to the incident.

In 2015 the IMPD was granted a Department of Justice/Bureau of Justice Assistance microgrant. As a result of the microgrant, the IMPD offered training on law enforcement wellness in 18 different cities across the United States. Approximately 700 officers from 150 agencies participated in the trainings. Results from a grant associated self-report-confidential survey only furthers the necessity for officer wellness programs nation-wide. Of the individuals surveyed 22% of officers had contemplated suicide, 75% had experienced what they viewed as overwhelming stress and 44% had dealt with Post Traumatic Stress. In 2019, 228 Police Officers completed suicide.[iii] During the same year 134 officers were killed in the line of duty.[iv] 362 officers deceased at their own hand or by the hand of another. What the number 362 does not so obviously reflect are the thousands of officers, and their family members, who are suffering. Historically, it has been culturally inherent for officers to suffer their pain in silence. Some who have asked for help have been ostracized, lost their ability to carry their firearm and even retired without a pension due to Post Traumatic Stress not being recognized as a medical injury. The paradigm is now beginning to shift and concepts like wellness and resiliency are becoming culturally accepted. The transformation makes the manner in which an agency responds critically important. The collective data on the trauma associated with police service, substance abuse rates, levels of suicide, and inconsistent levels of job performance all underscore the ever increasing need for consistency, on a national scale, in legislated confidentiality, funding sources, referral resources and established policy and best practices.

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[i] "Indiana HB1122." *TrackBill*, trackbill.com/bill/indiana-house-bill-1122-critical-incident-stress-management-services/1323294/.

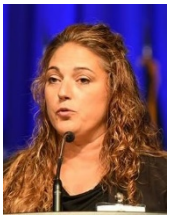
[ii] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4734407/

[iii] "Home." *Blue H.E.L.P.*, bluehelp.org/.

[iv] "2019." *The Officer Down Memorial Page (ODMP)*, www.odmp.org/search/year/2019.

Sherri Martin

Fraternal Order of Police



Sherri Martin serves as the National Director of Wellness Services for the Fraternal Order of Police (FOP), the largest representative organization of law enforcement officers in the United States. A career police officer, Sherri has extensive experience in crisis negotiation and intervention, serving most of her law enforcement career as a patrol supervisor and lead crisis negotiator. While a member of the Charleston Police Department in South Carolina, where she served the bulk of her career, she achieved the rank of Lieutenant, and was responsible for the development of programs in the areas of officer wellness and crisis intervention within the community.

Sherri earned a Bachelor of Science degree in Psychology from the University of North Carolina and a Master of Arts degree in Clinical Counseling Psychology from the Citadel, where she was chosen by faculty to receive the J. Patrick Leverett Award presented to the most outstanding graduate student in the Psychology program. Additionally, Sherri has experience in clinical therapy, having worked with clients suffering from PTSD and Clinical Depression during research conducted at Ralph H. Johnston Veterans Affairs Hospital in South Carolina. She is licensed as a Professional Counselor Associate in the State of Connecticut. While pursuing a Postgraduate Certificate in Forensic Psychology at John Jay College of Criminal Justice, Sherri led the Fraternal Order of Police National Officer Wellness Committee in a landmark survey of police officers on the subjects of critical stress, stigma, and use of wellness services.

Sherri is a member of the National Consortium on the Prevention of Police Suicide, led by the International Association of Chiefs of Police, and has served as a contributor on various symposia on officer wellness and police suicide. Along with the FOP National Officer Wellness Committee, Sherri is currently working on the development of a national database of culturally competent mental health providers for law enforcement. In partnership with the Office of Community Oriented Policing Services of the US Department of Justice, the Fraternal Order of Police has additionally received funding for the development of a nationally standardized curriculum in law enforcement peer support. Based upon the survey research conducted by the FOP, peer support is viewed by law enforcement officers as being the most effective intervention in times of crisis, despite over 90% of members of the profession feeling that there is a stigma against asking for help. To that end, Sherri and the FOP National Officer Wellness Committee are working to build a nationwide network of trained peer supporters that will enable an officer in crisis to find a peer anywhere in the country.

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JIMMY HOLDERFIELD
NATIONAL SECRETARY

TESTIMONY TO THE PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND THE ADMINISTRATION OF JUSTICE
February 27, 2020

Sherri A. Martin
National Director of Wellness Services
Fraternal Order of Police

Focus area: Mental Health and Wellness
Topics addressed: Suicide in law enforcement, use of services by officers, stigma around help-seeking, development of solutions

In the past 24 months, a great deal of attention and focus has been placed on the staggering rate of suicide among the law enforcement profession in our country. We know that deaths by suicide claim the lives of far more of our brothers and sisters than do deaths in the line of duty. Although this issue is not a new one, it has received unprecedented attention in the profession in the past several months, and with good reason. Now is the time to make the changes necessary to stem this tide.

In late 2018, the Fraternal Order of Police, in partnership with NBC New York, conducted a nationwide survey of active and retired law enforcement officers on the topic of mental and behavioral health. The goals of the Fraternal Order of Police in distributing this survey were to gauge the prevalence of critical stress suffered by our nation's law enforcement officers, identify the availability or lack thereof of wellness services available, discover the barriers to service usage, and to fill the gap to develop programs to assist those officers in need. The responses of over 8000 law enforcement officers across this country provided us with some important answers.

We learned that a significant number of respondents have faced times of critical stress during their law enforcement careers, and that they believe that these crises have led to unresolved emotional or mental health issues. As consequences of these issues, respondents reported sleep problems (65%), family and relationship problems (52%), increased irritability and anger (62%) and a change in the way that they view the job and the future (59%). Despite this prevalence of personal difficulties, officers are not discussing them openly or seeking help with them because over NINETY PERCENT feel that there is a stigma in the law enforcement profession that prevents them from doing so.

The sources of the stigma are many and come from sources both inside and outside of the profession. In our survey, about half of respondents indicate concerns that mental health service providers won't understand the nature of the job of a police officer. Based on accounts from both officers and professionals in police psychology, this is a real issue, and points to the need for greater identification of specialized services for the treatment of law enforcement officers and

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other first responders. Because of stigma, some fear the impact that asking for help will have on their families, when in actuality services should ideally strengthen families.

Perhaps most telling, however, are the statistics related to stigma from within the profession. In our survey, eighty-five percent (85%) report a concern about being seen as weak or unfit for duty, and seventy-six (76%) report concerns about putting their job at risk, should they admit struggling with issues and seek out help. These sources of stigma fall within our realm of control, and these statistics indicate the need for cultural change and a shift in dialogue. With a significant number of our officers struggling with emotional issues at some point in their career, none of us is immune, and we must begin work to normalize these experiences so that our officers don't feel that they will be judged when they reach that point of struggling. Simply put, this fear of judgment is killing our brethren.

Law enforcement officers are resourceful problem-solvers, and although many develop effective wellness skills to cope with the pressures of the job and the surrounding lifestyle, issues sometimes override those coping mechanisms. Our officers exercise to relieve stress, engage in personal hobbies, talk with family and friends when they feel stressed, and some do seek out professional services when needed. However, research indicates that far greater education is needed to increase the level of wellness of our nation's police officers. Although most officers are aware of resources within their agencies, and are provided training and information regarding their availability, the majority of officers have not used employer-provided services and indicate a belief that those services lack effectiveness. The reasons for this may be varied but are likely closely related to the stigma associated with help-seeking.

Despite the overarching theme of lack of faith in agency-provided mental health services, there are some positive indicators for solutions. Approximately one-third of respondents indicated that they had sought professional mental health counseling outside of their employer. This figure indicates that officers are aware of the issues that are created by their job, and aware of the effects that it may have on their health and their families, and many know that they could benefit from professional services. The majority of those who indicated that they worked with professionals outside their employer indicated that it was a positive and helpful experience. We can draw the conclusion that the stigmas within the job prevent those officers from using services provided by the workplace.

Three out of four respondents to our survey indicated that they prefer trained peer support as an intervention in times of crisis. As a matter of common sense, we know that peer support is the most comfortable and convenient intervention for an officer in a time of crisis. With trained peer supporters in place, an agency can provide immediate access to a person who can relate to and understand the experiences of an officer, whether it be a critical incident or a family issue. The stigma of seeking help is greatly reduced when it feels like a casual chat with a friend. Trained peer support provides the greatest chance to reach officers in crisis, and to potentially be the bridge to professional services when needed.

It is the mission of the Fraternal Order of Police to increase awareness about behavioral health and post traumatic stress in law enforcement, as over 90% of our survey respondents indicate a belief that greater awareness will lead to improved services. A heartbreaking 96% of respondents indicate a belief that there is a lack of awareness among the public about the effects that critical stress has on law enforcement. Our officers need support in the form of word and

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action. They need the public they serve to be aware that they are human, and that this profession is a difficult one that often generates health consequences in the heroes that take it on.

Just a few weeks ago, the Fraternal Order of Police Officer Wellness Committee held our first National Wellness Summit in Nashville, Tennessee. The Summit brought together experts in resilience, peer support program building, posttraumatic stress, financial wellness, and other topics related to officer health and wellness. It also brought together like-minded members of our profession, who recognize the issues that our brothers and sisters are facing and are bravely and enthusiastically building the conversation that will eventually erase the stigma. The first of what will become an annual event, the 2020 FOP Wellness Summit is an example of how we are working toward culture change in our profession.

Using data from our survey and other research in the field, the Fraternal Order of Police is engaged in several efforts to build needed services for our members of law enforcement. Through contacts with police officers across the country, we are establishing a nationwide directory of culturally competent mental health and wellness providers, programs and services for law enforcement. We are seeking out and vetting those providers who are committed to and skilled at working with our unique population, and crafting a resource where officers can find them in times of need.

The employment of trained peer support is an unmatched resource for law enforcement. At present, there is a lack of standardization in law enforcement peer support training in the country. In cooperation with the Office of Community Oriented Policing Services, the Fraternal Order of Police is in the process of developing a standardized curriculum in law enforcement peer support. ***Power In Peers***, as this curriculum will be titled, is expected to become certified nationally available training in the future. Through delivery of this training, the National Fraternal Order of Police will generate a nationwide network of trained law enforcement peer supporters which will hopefully grow with each passing year. It is only through constant conversation about the wellness of our officers that we will succeed at stemming the tide of law enforcement suicide. This must not be a topic from which we divert our attention.

A report of the FOP's landmark Survey of Law Enforcement Behavioral and Mental Health can be found on our organization's website at www.fop.net. In addition, I stand ready to discuss the efforts of the National Fraternal Order of Police and the work of our Officer Wellness Committee. I can be reached at sherrimartin@fop.net or by phone at (843)270-2184.

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Witness Biography

Sherri Martin serves as the National Director of Wellness Services for the Fraternal Order of Police (FOP), the largest representative organization of law enforcement officers in the United States. A career police officer, Sherri has extensive experience in crisis negotiation and intervention, serving most of her law enforcement career as a patrol supervisor and lead crisis negotiator. While a member of the Charleston Police Department in South Carolina, where she served the bulk of her career, she achieved the rank of Lieutenant, and was responsible for the development of programs in the areas of officer wellness and crisis intervention within the community. Sherri earned a Bachelor of Science degree in Psychology from the University of North Carolina and a Master of Arts degree in Clinical Counseling Psychology from the Citadel, where she was chosen by faculty to receive the J. Patrick Leverett Award presented to the most outstanding graduate student in the Psychology program. Additionally, Sherri has experience in clinical therapy, having worked with clients suffering from PTSD and Clinical Depression during research conducted at Ralph H. Johnston Veterans Affairs Hospital in South Carolina. She is licensed as a Professional Counselor Associate in the State of Connecticut. While pursuing a Postgraduate Certificate in Forensic Psychology at John Jay College of Criminal Justice, Sherri led the Fraternal Order of Police National Officer Wellness Committee in a landmark survey of police officers on the subjects of critical stress, stigma, and use of wellness services. Sherri is a member of the National Consortium on the Prevention of Police Suicide, led by the International Association of Chiefs of Police, and has served as a contributor on various symposia on officer wellness and police suicide. Along with the FOP National Officer Wellness Committee, Sherri is currently working on the development of a national database of culturally competent mental health providers for law enforcement. In partnership with the Office of Community Oriented Policing Services of the US Department of Justice, the Fraternal Order of Police has additionally received funding for the development of a nationally standardized curriculum in law enforcement peer support. Based upon the survey research conducted by the FOP, peer support is viewed by law enforcement officers as being the most effective intervention in times of crisis, despite over 90% of members of the profession feeling that there is a stigma against asking for help. To that end, Sherri and the FOP National Officer Wellness Committee are working to build a nationwide network of trained peer supporters that will enable an officer in crisis to find a peer anywhere in the country.

Michael McHale

National Association of Police Organizations

Michael "Mick" McHale serves as the National President of the National Association of Police Organizations. Mick is currently a Police Officer at the Sarasota Bradenton International Airport and recently retired as an Administrative Sergeant in charge of the Canine, Marine Patrol, Traffic Unit and Honor Guard for the City of Sarasota Police Department, Sarasota, Florida. Mick is the President of the Southwest Florida Police Benevolent Association and Senior Vice President of the Florida PBA. Prior to becoming President of the National Association of Police Organizations (NAPO), Mick served as Executive Vice President, Recording Secretary, Area Vice President and Sergeant at Arms. Mick has also served on several committees, including as Chairman of the Committee on Political Education, where he was responsible for overseeing the evaluation and endorsement of candidates for elective office across the country.

Mick began his career with Sarasota P.D. in 1990 and has served as a Patrol Officer as well as a Narcotics Detective (for 10 years), prior to being promoted to Sergeant. Mick also served as a Commissioner with the State of Florida Criminal Justice Standards and Training Commission for a 6 year period after being appointed as a rank and file representative by then-Governor Charlie Crist.

The National Association of Police Organizations represents some 1,000 professional police associations and units and 241,000 sworn officers throughout the United States. NAPO serves its members through the advancement of federal legislation and policy, legal advocacy, and education.

President's Commission on Law Enforcement and the Administration of Justice
Hearing on Officer Safety, Health, and Wellness
February 27, 2020

Statement of Michael McHale, President, National Association of Police Organizations

This testimony focuses on officer mental health and wellness and includes the topics of peer mentoring programs, confidentiality of critical incident stress debriefings, and post-traumatic stress disorder (PTSD) as a covered condition under workers' compensation laws.

My name is Mick McHale and I am the President of the National Association of Police Organizations (NAPO) and the President of the Southwest Florida Police Benevolent Association. I am submitting this statement today on behalf of NAPO, representing over 241,000 active and retired law enforcement officers throughout the United States. NAPO is a coalition of police unions and associations from across the nation, which was organized for the purpose of advancing the interests of America's law enforcement officers through legislative advocacy, political action and education.

State and local law enforcement officers are our nation's first responders. They respond to our country's greatest tragedies as well as violent and abhorrent crimes that unfortunately occur with some frequency in our communities. They have seen and experienced horrors that they cannot forget, yet they continue to put their lives on the line every day to protect and serve our communities. These daily realities of the job most certainly affect officers' mental health and wellness.

According to Blue H.E.L.P., 228 current or active duty officers died by suicide in 2019, well over the 128 officers that were killed in the line of duty last year. In 2018, there were 172 officer suicides. 28 officers have taken their own lives so far this year. These are just the numbers that are reported and tracked. With officer suicides an area of great and increasing concern, it is vital that officers have access to trusted, confidential mental health and wellness services.

Given the time and space constraints of this testimony, I will focus on two topics that are top priorities for NAPO: officer peer mentoring programs and post-traumatic stress disorder (PTSD) as a covered condition under workers' compensation.

Many officers are reluctant to seek help, especially through services offered by their agency. They worry about confidentiality, fear that admitting their need for help will jeopardize their employment or believe the mental health specialists provided will not understand what they are going through, what they have experienced. This is where peer support programs play a vital role, whether they are peer crisis lines, peer-led critical incident stress debriefings, or other peer support services.

I will not go into great detail about the merits and best practices of peer mentoring programs as part of a department's or agency's officer safety and wellness program as the Department of Justice's Office of Community Oriented Policing Services (COPS) released two excellent reports covering these issues in March of 2019: *Law Enforcement Mental Health and Wellness Act Report to Congress* and *Law Enforcement Mental Health and Wellness Programs: Eleven Case Studies*. The COPS Office worked closely with NAPO and law enforcement organizations and agencies across the country on these two reports and I consider them mandatory reading for the Commission and this Working Group.

Every officer in this nation should have access to a peer mentoring program. Recommendations 13, 14, 15, and 18 from the *Law Enforcement Mental Health and Wellness Act Report to Congress* regarding peer mentoring programs are vital ones that NAPO urges the Commission to include in its final recommendations on Officer Safety, Health and Wellness:

Recommendation 13[1]: Support the expansion of peer support programs to ensure all officers have access to this important wellness service.

Recommendation 14[2]: Support the expansion of peer programs to include broader health and wellness, not just critical incident stress.

Recommendation 15[3]: Support alternative models to agency-specific peer programs, such as through regional collaborations or labor organizations.

Recommendation 18[4]: Improve legislative privacy protections for officers seeking assistance from peer crisis lines and other peer-support services.

Regarding **Recommendation 15**, I want to highlight the Peer Support Quiz (masscoppeersupportquiz.org) that is offered by one of NAPO's member organizations, the Massachusetts Coalition of Police (MassCOP), and supported by the American Foundation for Suicide Prevention. This is the first in the nation, statewide Police Union Peer Support program that is available for any officer – not just union members – who need to and want to use it. The self-check quiz serves as a convenient and safe way for officers to anonymously communicate with a peer support officer about available service options so they can address their mental health concerns before they escalate. MassCOP has partnered with the Leader Program at McLean Hospital (https://www.mcleanhospital.org/treatment/leader) to provide mental health and addiction services for those officers who need it.

Because this program is run by the Union – an organization highly trusted by rank-and-file officers – officers may be more willing to seek and use the services because they trust that the Union has their best interest at heart. If a department or agency establishes its own mental health and wellness programs, it is imperative that they collaborate with the union or officer association in order to ensure they get the buy-in of rank-and-file officers, those who will be using these services. Without the input and support of these organizations, line officers could distrust a program run by their department and decide not to use it for fear it could negatively impact their job.

This brings me to **Recommendation 18**. Officers are public servants. Unless the strictest privacy standards are established and maintained, an officer's mental health care, including that through peer mentoring services, can be discoverable on the public record, used in court proceedings, or affect their employment. Officers feel more comfortable admitting their concerns and asking questions and are more likely to take advantage of mental health services when they know they will be confidential.

Only 22 states provide confidentiality protections to critical incident debriefs and peer support services.[5] In these states, the group debriefings, conducted by peer support and mental health professionals, are protected. Do-not-discuss orders are suspended for the duration of the debriefing and officers are free to discuss their feelings and concerns. All communications and records kept during these debriefings may not be disclosed in a civil, criminal, or administrative proceeding, with certain, limited exceptions. For examples, see the Texas and Washington state laws.

Additionally, there is a gap in the Federal Rules of Evidence governing confidentiality in officer use-of-

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[1] *Law Enforcement Mental Health and Wellness Act Report to Congress*, p. 32
[2] *Law Enforcement Mental Health and Wellness Act Report to Congress*, p. 33
[3] *Law Enforcement Mental Health and Wellness Act Report to Congress*, p. 33
[4] *Law Enforcement Mental Health and Wellness Act Report to Congress*, p. 36
[5] https://le.utah.gov/interim/2017/pdf/00002716.pdf

force peer debriefs - these debriefings are not currently protected, although the statements of a criminal suspect in the very same incident who speaks to a therapist *would be* privileged from disclosure. A result of this gap is that officers are sometimes advised by counsel not to participate in the debriefings and therefore do not get the benefits available from the experience.
NAPO strongly supports Recommendation 18 and the need to enact legislation that makes all communications made by officers to crisis counseling services (including peer services), and all records related to the communications, confidential.

Further Recommendation: **Amend the Federal Rules of Evidence to expand the privileges section (Rule 501) to exclude from introduction into evidence in federal proceedings statements made by an officer in the context of critical incident peer debriefs and peer-involved mental health care for officers involved in highly stressful situations.**

While peer mentoring and mental health and wellness programs can be extremely effective at preventing the development of post-traumatic stress symptoms, these symptoms are sometimes unavoidable given what officers experience in the course of their duties. Further, hundreds of thousands of police officers across the nation do not have access to any form of workplace mental health and wellness programs. These law enforcement officers have to foot the bill for their own mental health services – a big obstacle to ensuring officers get the mental health and wellness help they need.

Two-thirds of states cover PTSD under their workers' compensation programs. However, state laws covering PTSD vary to a great extent: some cover only if there is a corresponding physical injury, some will only provide coverage if the qualifying event was "unusual" or "sudden" and then some do cover "mental-only" injuries.[6] We believe that all states should provide "mental-only" coverage to ensure all law enforcement officers struggling with work-related PTSD are covered.

NAPO's member organizations have been leading the charge in their states to either establish or strengthen state workers' compensation laws relating to covering first responder PTSD, including the Florida Police Benevolent Association. I helped lead the efforts on behalf of the Florida PBA to enact a law in Florida in 2018 (SB 376)[7] to expand workers' compensation to allow first responders to seek treatment and take time off following a PTSD diagnosis, whether or not a physical injury also occurred.

Arizona, California, Colorado, Connecticut, Florida, Idaho, Louisiana, Nevada, New Hampshire, New Mexico, Oregon, Texas, and Washington have all passed laws addressing benefits for first responders with "mental-only" PTSD injuries. In 2019, at least 26 states considered new legislation addressing workers' compensation coverage for PTSD and other "mental-only" injuries for first responders.[8]

Recommendation: **Support legislation or mandate that "mental-only" PTSD injuries be covered under workers' compensation for first responders and that the PTSD will be presumed to be work-related.**

I appreciate the opportunity to share these insights with you, and urge you to carefully consider them moving forward, as your recommendations on Officer Safety, Health and Wellness will greatly impact our officers.

Michael "Mick" McHale, President, National Association of Police Organizations
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[6] https://www.gerberholderlaw.com/workers-comp-ptsd-by-state/
[7] https://www.flsenate.gov/Session/Bill/2018/376/BillText/Filed/PDF
[8] https://www.ncci.com/Articles/Documents/II_Regulatory-Legislative-Trends2019.pdf

Karen Solomon

Blue H.E.L.P.

Karen Solomon is the co-Founder and President of Blue H.E.L.P., Inc. and creator of www.1sthelp.net. She is the author of Hearts Beneath the Badge and The Price They Pay as well as many articles about law enforcement suicide, her focus is the stories of the families who have lost an officer to suicide and the officers who suffer with the feeling that they have nowhere to turn.

Karen was a member of the 2018 Officer Safety and Wellness Group Meeting and is currently the co-Chair of the Data and Research Committee of the National Consortium on Law Enforcement Suicide Prevention. She has spoken at many private, public and government events regarding law enforcement suicide.

Married to a police officer since 2001, Karen understands today's challenges and puts her knowledge to work on behalf of the entire profession. A survivor of three suicide attempts, Karen is a passionate advocate for suicide prevention and has chosen to bring that intensity to law enforcement.

Karen has a bachelor's degree in Political Science from Eckerd College. She's a member of the International Law Enforcement Educators and Trainers Association (ILEETA), the National Association of Women Law Enforcement Executives (NAWLEE), and the Public Safety Writers Association.

Karen Solomon
President, Blue H.E.L.P.
Focus Area – Support: Family Support, Stigma Reduction, National Resources

Blue H.E.L.P. (BH) has recorded 711 law enforcement suicides, including 86 retirees, from January 1, 2016 through December 21, 2019. In all, BH has 1,172 suicides in their database with over 30 data points for the suicide including personal issues which can help understand the life issues an officer was experiencing at or before their death.

During the same time period 653 officers have died "in the line of duty" from twenty-four different causes of death. In any given year, approximately 60% of the line of duty deaths are non-felonious assaults. Meaning, the officers are not "killed" in the line of duty, they die of duty-related illness, various accidents or heart attacks while in uniform. While gunfire makes up 35% of LODD; 9/11 deaths (16%), automobile crashes (15%) and heart attacks (11%) remain firmly in the top four causes. (source: Officer Down Memorial Page) Notably, officers are killing themselves more often that they are being killed by others.

Prior to BH's data collection effort, suicides were tracked in 2008, 2009 and 2012 by another non-profit organization, most of the members have now joined BH. In the past, this sporadic data collection has been cited and studied numerous times despite the insufficient data, five data points, and inconsistent collection. While we would never consider recording LODD and assaults on a sporadic, incomplete basis, we have historically accepted that suicide does not warrant the attention we give to other deaths. Without tangible data and specific needs of the affected families and officers, we may not be offering meaningful support.

Before and after a suicide, officers and their families battle stigma, uncertainty and a fractured support system. The four things that are most lacking in law enforcement currently are a national database of law enforcement suicide like LEOKA; a central, vetted repository of support; a united, open dialogue about suicide and, support for the families in the aftermath. While BH is well known for its database on LE suicide, there are multiple bills being proposed for national data collection which is why we are using our limited time to discuss the families and the stigma.

"Unlike other variables, stigma and discrimination - whether at the societal or individual level - are in principle modifiable risk factors."[1] "With the aim of preventing suicide, greater efforts should be made to combat the persisting stigmatizing attitudes displayed toward mental disorders and suicide itself. Indeed, the role of stigma as a risk factor for suicide should further motivate and spur more concerted efforts to combat public stigma and support those suffering from perceived or internalized stigma. Experts and scientific societies should form an alliance with the media to promote a marked change in the societal perception of mental health issues and suicide."[2]

The cited research affirms our belief that without an open, supportive dialogue, we cannot reduce the stigma associated with suicide. Recommendation 1 of the 2019 Law Enforcement Mental Health and Wellness Act (LEMHWA) is "Support the creation of a public service campaign around law enforcement officer mental health and wellness in conjunction with National Mental Health Month." Consideration 8 of the Officer Safety and Wellness Practices in

[1] Rüsch, Nicolas. "Does the Stigma of Mental Illness Contribute to Suicidality?" Cambridge Core, Oct. 2014
[2] Carpiniello B, Pinna F. The Reciprocal Relationship between Suicidality and Stigma. Front Psychiatry. 2017;8:35. Published 2017 Mar 8. doi:10.3389/fpsyt.2017.00035

Modern Policing is "Document, celebrate, and publicize successes."[3] Finally, the IACP also recommends that we "Address mental health awareness at National Police Week every May as a way to show unity on the issue".[4]

Recommendations have been repeatedly put forth to reduce the stigma, yet, other than BH, few have been willing to step forward and create an impactful campaign. In 2019, BH hosted the first ever dinner to honor the service of officers lost to suicide by bringing over 40 families to Police Week. BH hosted the dinner to begin leading the change and force a conversation, the organizers of Police Week declined our invitation to participate and have again declined our invitation for 2020.

The members of the 2018 Officer Safety and Wellness Group noted the lack of leadership surrounding this issue. "According to participants, lack of leadership around mental health wellness is perpetuating a culture of silence around mental health issues."[5] Progress, however, has been made outside of the organizers of Police Week, the IACP, NOBLE, FLEOA and NAWLEE assist and participate in the organization of the event. This is not enough, if the families are denied recognition by the very event that is devoted to *all* law enforcement, they are being re-stigmatized and further emotional damage is being inflicted on them by the very organizations that seek to honor our police men and women. BH calls on the commission and national organizations that support LE to take over leading this change with action.

Further, the most recent #IWILLLISTEN campaign by BH has meaning and roots, but again lacks the support that is given to dance and lip-sync challenges. While we are busy trying to make the public see us as more human, we are forgetting to provide that message to ourselves.

"Results demonstrated that suicide survivors experience stigma in the form of shame, blame, and avoidance. Suicide survivors showed higher levels of stigma than natural death survivors."[6] In addition to refusing to acknowledge the families at police week, or offer them any sort of organized support, we also fail them immediately following a death. There is no formal protocol for the funeral, initial support or explanation of benefits (or lack thereof). As in the case of Deputy Omar Calderon, many families are denied the basic off-duty honor they are entitled because of the bias on the part of the department or because people simply do not know what to do. Firm policies need to be put into place, and followed, regardless of personal feelings, by all departments around the county. "Following a police suicide, agencies should reach out to surviving family members and provide support, including assistance with obtaining any available benefits, and appropriate funeral honors."[7]

Families also need somewhere to turn, at this time BH offers care packages, funeral assistance, scholarships and now, thanks to the Motorola Foundation, retreats for children who lost an officer to suicide. Nationally, efforts are made to support other officers who die off duty and more comprehensively, those lost in the line of duty. While we have asked for guidance and

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[3] International Association of Chiefs of Police. 2018. Officer Safety and Wellness. Practices in Modern Policing. Alexandria, VA: International Association of Chiefs of Police.

[4] International Association of Chiefs of Police. 2017. Breaking the Silence on Law Enforcement Suicides: IACP National Symposium on Law Enforcement Officer Suicide and Mental Health. Washington, DC: Office of Community Oriented Policing Services.

[5] Strategic Applications International. 2018. Officers' Physical and Mental Health and Safety: Emerging Issues and Recommendations. Officer Safety and Wellness Group Meeting Summary. Washington, DC: Office of Community Oriented Policing Services.

[6] Hanschmidt F, Lehnig F, Riedel-Heller SG, KerstingA (2016) The Stigma of Suicide Survivorship and Related Consequences—A Systematic Review. PLoS ONE 11(9): e0162688. doi:10.1371/journal.pone.0162688

[7] Police Executive Research Forum. 2019. An Occupational Risk: What Every Police Agency Should Do To Prevent Suicide Among Its Officers. Critical Issues in Policing Series. Washington, DC: Police Executive Research Forum.

assistance on this path, we have again been ignored or denied by LE organizations but embraced by military organizations who have already made immense strides in family assistance and stigma reduction. Until there is a formal outlet for these families to seek support, we are again perpetuating the myth that the service of these officers did not matter, they were cowards and their families are not deserving of our assistance. Until we join as a community, there will be no significant strides toward stigma elimination, healing or most importantly, a reduction in the number of officers taking their lives.

Finally, and no less important, a common statement made by families after a loss is. "I didn't know where to get help and I didn't want him to lose his job." Also frequently stated by officers, "Who am I supposed to call? I can't lose my job." Providing a central repository for officers and their families to seek help is mandatory. Research need not be quoted, although there is plenty of it, to show that officers simply do not know where to turn and feel comfortable knowing it is confidential. BH has slowly developed a database, www.1sthelp.net, as a starting point for first responders, but our efforts are weak in comparison to what other national organizations can develop. Officers calling any of the multiple hotlines available to them receive varying degrees of assistance and care, each one provides a different type of service but there is no guidance on what to expect and whether these are vetted resources.

Police departments around the country are implementing wellness programs and independently vetting resources. Oftentimes, these departments are replicating from scratch something that has already been done. With no central resource, they cannot leverage the success and learn from the failures of other departments around the country. The NLEOM Destination Zero awards is an excellent resource for a department looking to speak to someone who has a successful program in place. They need only contact the winners or the nominees, how many officers would think to look there? Recommendation 15 of LEMHWA - Support alternative models to agency specific peer programs, such as through regional collaborations or labor organizations.

The solutions are already identified, what is missing is collaboration, visibility and action. We humbly recommend that the commission revisit the recommendations that have already been made in multiple documents over the years. Resources should no longer be devoted to discussing the issue, forming committees or hosting symposiums, the resources should be directed to implementing previously published recommendations.

In closing, please remember Officer Phillip High, he took his life just 30 days from retirement. He needed, and wanted, inpatient treatment, but was afraid to ask for time off. After his wife asked the Chief about leave, he uttered the words "You just ruined my life!" before shooting himself. Officer Max Scherzer sought help for years; his department was unable or unwilling to provide it. He took his life after a night of drinking and his 4-month-old twins received no support. Five months prior, the laws in New Jersey were changed to accommodate the children an unmarried officer stuck by a car with half the time on the job. The wife who called 9-1-1 thinking her husband took his life, when finding out he was alive, there was no joy. She begged the first responders to pretend she never called, she felt she just ended his career. Remember the countless children that are not walked to the first day of kindergarten or taken to prom, the wives who find out they receive no benefits and the officers that are told they cannot wear mourning bands or provide an honor guard. Most importantly, remember the officers who are struggling today and need solutions, not promises or talk. If this isn't enough, we can provide you with hundreds of families that will testify to their deep desire for this not to happen to another family.

Janice McCarthy

Care of Police Suicide Survivors

Janice McCarthy's husband, Paul, died from suicide in July of 2006. Paul had been a well respected Massachusetts State Police Captain. During his 21-year career he suffered three serious line of duty accidents, which proved to be the etiology of his PTSD. Paul's death spurred Janice to commit herself to the cause of PTSD recognition and suicide prevention in law enforcement Her passion is rooted in helping surviving families find the strength to reconcile the guilt so many suicide survivors experience. She draws upon her personal experience as a cops' wife and now as a cops' widow to connect with officers. She knows the law enforcement life and has been openly accepted by those to whom she has spoken.

In her training of officers, Janice uses Pauls' story to illustrate the need for all officers to reach out for mental health assistance without fear of repercussion. She calls for an end to the age-old stigma of asking for help. She clearly articulates how the "good old boy - suck it up" mentality was instrumental in fueling her husbands' deterioration.

She has spoken nationally, telling her familys' personal story in an attempt to reach officers on an emotional level. She appeals to officers as a cops' wife hoping that they might understand and appreciate their spouses' sacrifices. She speaks candidly and emotionally of her childrens' pain, hoping the officers might see their own kids in the images of Paul, Shannon and Christopher McCarthy. And she recounts witnessing firsthand her husbands' struggles, hoping the officers might associate themselves with Paul and realize the consequences of not reaching out for help when they need it.

Her experience as a lecturer has included weekly recruit and officer in-service training in New Haven, Connecticut. That training has been incorporated into the Connecticut State Police Academy recruit training requirements. In addition, she has presented at the Asian American Police Officers Association Annual Conference, the 6th Annual Law Enforcement Employee Assistance Conference in Harrisburg, Pennsylvania, The Pennsylvania Board of Probation and Parole CIRT training, the California Peer Support Association Annual Conference, and the 2015 Internal Affairs Annual Conference. She has lectured FBI agents and federal employees in Philadelphia, New York City and the National Academy at Quantico. She was guest speaker at the 2013 In Harms Way annual conference and the American Association of Suicidology conference. She has trained California Correctional Officers , University Police Chiefs of Massachusetts, Massachusetts Police Recruits and is a frequent guest lecturer for Connecticut Alliance to Benefit Law Enforcement (CABLE). She has worked with the Samaritans of Merrimack Valley constructing and facilitating suicide prevention training for Middle Age Men.

She is a recipient of The Commendable Service Award from the City of New

Haven Connecticut, and The Departmental Award of Education from the New Haven Connecticut Police Department for her devotion to the cause of suicide prevention and PTSD awareness in law enforcement. In addition, she is the recipient of the 2018 MCSP Leadership in Suicide Prevention award. She is the founder of C.O.P.S.S. (Care Of Police Suicide Survivors), which is a nonprofit foundation formed in her husbands' memory and dedicated to their children Christopher, Paul and Shannon. The foundation provides Care and Support for law enforcement suicide survivors and suicide prevention training for law enforcement.

In addition to her training and nonprofit work, she has authored several short papers on "Policework, PTSD and its Aftermath". She is Co-Sponsor of House Bill 2140 in Massachusetts which would mandate Suicide Prevention Training for First Responders in the state. She considers her greatest achievement to be her three children whose strength and love fuel her.

2020 IACP Officer Safety and Wellness Symposium

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For the purpose of this symposium I will address separately Prevention Support Responsibilities and Post-vention Support Responsibilities. Initially it is essential to define the issue at hand.

1. Identify the problem- A proliferation of law enforcement suicides
2. Identify change needed- Elimination of Stigma
   Training
   Uniform Policies and Protocols protecting jobs and pensions
   Uniform Policies and Protocols addressing Post-Vention Services
3. Identify the players that have the ability to initiate these changes-
   Administrators
   Unions
   Legislators
4. Identify Barriers to success-
   Administrators
   Unions
   Legislators

Stigma:

It is an unfortunate paradox that those groups with the power to enact change are the same groups that impede change. Change **MUST** come from the top down. Chiefs, Union Leaders and Legislators must all "Buy In" to the reality of this crisis and the absolute necessity to address it. Doing so not only increases the likelihood of success but goes a long way in eradicating stigma surrounding mental health among our officers.

In 1996 the US Air Force recognized a suicide problem within its ranks. They initiated The US Air Force Suicide Prevention Program. In 2008 data showed suicide rates were significantly lower after the program than before.[1] The program utilized high ranking Officers speaking candidly about their struggles with mental illness. Part of the success of the program is attributed to the willingness of these Officers to share their stories and lead by example.

Recommendation- Institute a Mental Health Awareness Campaign in which Law Enforcement Leaders share their struggles with mental wellness and the value they found in treatment. This would help eradicate stigma and illustrate the importance and effectiveness of seeking treatment.

Prevention Training Programs:

Training educates officers to recognize dangerous and potentially life threatening symptoms in themselves and fellow officers. It validates their emotions in the aftermath of a traumatic incident and it breaks down stigma. Education replaces the "Suck It Up" mentality that is pervasive in Law Enforcement with the **FACTS** on the importance of maintaining mental wellness and utilizing positive coping skills.

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[1] The US Air Force Suicide Prevention Program: Implications for Public Health

Since the 1970s (with the exception of 2001) the number of LOD deaths has decreased or remained steady while the number of officers nationwide has increased. [2] During this time period great advances have been made to protect the physical well being of our officers including the introduction of bullet proof vests and tasers. Training programs abound on topics such Deescalation, Defensive Tactics, Firearms and Community Policing. Many departments require officers to adhere to established physical fitness standards all in an effort to keep our them physically well. From January 1, 2016 to June 31, 2019 we lost 576 officers to suicide[3] in this country. As documented above increases in training and equipment advances have gone a long way in protecting our officers physically. But what are we doing to protect them from the emotional toll this job can take on a human being?

In my home state of Massachusetts the only training officers receive on maintaining their mental health is a 2-hour-block in the Academy. Currently, I am Co -Sponsor of House Bill 2140 which would mandate Law Enforcement Wellness Training right along with the Deescalation and Defensive Tactics Training. It is imperative officers know that we value their emotional health as much as their physical health. We would not send an officer out on patrol without his firearm and bullet proof vest which protect him from physical assaults. Why then would we send that same officer out on patrol without training him how to emotionally survive the stress and trauma inherent to this job?

Recommendation- Until Administrators and Unions "Buy In" on prioritizing officers Mental Wellness we must partner with Legislators to enact legislation **mandating** Emotional Wellness Training.

Post vention:

My experience and those of many other widows of Law Enforcement Suicide has been that of shameful treatment and non-existent protocols on the part of Police Agencies and other Support Organizations. Many widows report that their health insurance was terminated the day the officer died. There was no assistance regarding a pension if there was a pension at all. One widow recounted, "The morning I found my husband in the garage the Chief sat on my couch and told me "we let Jeff down. He talked about how they would properly honor him. Instead of honoring my husband for his 27 years of dedicated service all honors were removed from my husbands service at the last minute. My children and I were devastated!!" Another wrote: "The department never bothered to check to see if my brother and I were doing ok - never!"

My families experience also included having our health insurance terminated. And the honor afforded to Paul was epitomized by the tattered and ripped paper bag which was slid under a 2" thick glass partition in the lobby of Headquarters. It contained Paul's badge, ID and wallet still damp from lying on the ground next to his body for two days. In the course of his career three times I was notified that Paul had been critically physically injured, run over by a bus, hit by a drunk driver and dragged through a tunnel in Boston. Each time either his Partner or Captain appeared at my door with the news. The fourth time the uniform appeared at my door it was worn by two rookie troopers I did not know to tell me Paul was dead.

Recommendation- Create uniform policies on death notifications, funeral protocols, pension assistance, counseling assistance, health insurance issues. Assign a liaison to assist Survivors.

Stigma:

After my husband I contacted Concerns Of Police Survivors (COPS) regarding support services for my children who were 16, 14 and 8 at the time. I was told that my children were not eligible for these services because of the manner in which their Father died. COPS does wonderful things for LOD families. But make no mistake, their exclusion of Suicide Survivors perpetuates the stigma and loss these families already feel and tarnishes the memory of good officers who literally gave their life for this job.

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[2] National Law Enforcement Officers Memorial Fund

[3] Blue Help

My family and I soon realized that there was little to no support for Survivors. So in 2010 I founded Care Of Police Suicide Survivors(COPSS). We provide support for families after a loss and training for Officers to prevent suicide. The training includes a Powerpoint telling Pauls' story, sharing healthy coping skills and urging officers to take their mental health seriously. I was presenting at a conference several years ago and met a LOD widow who was there representing Concerns Of Police Survivors (COPS). I asked her if they had plans to include Suicide Survivors in their program and support offerings. "Won't happen" she said, "the difference between them and the real LOD deaths are that they made a CHOICE." Afterward I sat watching her Powerpoint presentation busting with smiling faces at summer camps, white water rafting trips, Outward Bound programs, memorial road races and candle lighting ceremonies at the Police Officers Memorial in DC, all sponsored by COPSS. As she moved from slide to slide extolling the support and benefits offered to surviving spouses, children, in-laws and even coworkers I felt myself coming unglued. My mind was engaged in an emotional tug of war. One side was a sense of gratitude that this help was available for grieving families and the other side was the difficult realization that this was not available for ***my*** family. Painful memories of my family's struggle for the most basic help in the wake of Pauls' death were being dredged back to the surface of my consciousness. My mind was flooded by the injustice of it all. Each slide she clicked through illustrated the stark difference in our experiences. Summer Camps…I prayed for just a return call on how to get his pension set up. White water rafting…no time for that, I had to fight to get our health insurance reinstated. Outward Bound trips…my challenges would not include hiking through dense foliage but rather wading through paperwork and referrals to get counseling set up to help my children simply make it through the day. I couldn't help but marvel at the fact that this woman and I should have had a common bond given we were both young widows whose husbands died tragically and were part of the law enforcement family which prides itself in taking care of its own. Yet instead of feeling a bond I felt distanced from her, her organization and the whole law enforcement family.

I felt an overwhelming desire to tell her about Paul About what a good cop and good man he was. About the night he was run over by a stolen bus shattering his legs into over 20 pieces. About how he suffered and gave his life for the job he loved. About the surgeries he underwent to simply walk again and return to work. About the nights it took him 45 minutes to make it up the stairs one painful step at a time. About the babies he saved, tires he changed and death notifications he made. About the friends he buried and the funerals he stood at attention at for so long that his injured legs swelled and his boots had to be cut off. About the nightmares and sleepless nights. About his children and the pain that is left for them . This pain is only exacerbated by the exclusion perpetrated on Suicide Survivors by Departments that return Badges and IDs in ripped paper bags and Organizations that **choose** to exclude.

Recommendation- Include Law Enforcement Suicide Survivors in programs and services.

Paul suffered with PTSD after being critically injured three times in the line of duty. He was diagnosed by a State Police Psychiatrist in 2016 whose recommendation was intensive in-house therapy. He agreed to go. The Department attached a stipulation to his receiving treatment. He must retire. He refused. Six weeks later he put on his uniform, got in his cruiser and drove to a deserted construction site where he put a bullet in his chest.
After he died I found a memo from Paul to the Massachusetts State Police in which he detailed the trauma that he had endured over his 20 plus years on the job. He cites example of other officers who like him, had been diagnosed with job-related PTSD and instead of being treated were labeled problem employees and encouraged to retire. He states, "This approach adversely affects the quality of life of these employees and their families. They should be offered a pension if they desire to have one. And they should be treated for the disorder so they can continue on with their lives as productive members of society." He ends by pleading for "Departments to provide policies for treatment and assistance to troopers and their families who have Post Traumatic Stress."
The department failed my Husband. Shame on them. And shame on us if we allow this to continue.

Recommendation- Listen and enact CHANGE

Stephanie Samuels

COPLINE

Stephanie Samuels is a psychotherapist who works exclusively with police officers in New Jersey, New York, Pennsylvania, and Oklahoma. Ms. Samuels has lectured all over the country on PTSD and vicarious trauma, including undiagnosed PTSD and the fallout from departmental silence after officers are involved in critical incidents.

Ms. Samuels began her career as one of the founding teens of Teen Line Cares, a mental health help line for teens. Ms. Samuels recognized that teens only trusted and confided in other teens. With this same concept in mind, Ms. Samuels went on to create two law enforcement officer hotlines. She is currently the Founder and President of COPLINE, Inc., the first Confidential National Law Enforcement Officers' Hotline in the country manned by retired officers.

She is the general partner of The Counseling and Critical Incident Debriefing Center, LLC, which specializes in debriefing and long term counseling of first responders and their families. She taught at the Monmouth County Police Academy for 16 years and has been a guest lecturer at The FBI Academy in Quantico. Ms. Samuels was hired after the Boston Bombing as the Clinical Director of the Boston Police Department Peer Support Unit and co-founded the LEADER (Law Enforcement Active Duty Emergency Responder) Program at Harvard's McLean Hospital and continues to work with the Boston Police Department in a different capacity.

Ms. Samuels has co-authored Under the Blue Shadow: Clinical and Behavioral Perspectives on Police Suicide with Dr. John Violanti and a chapter entitled "Police Trauma: Past Exposures and Present Consequences" in the book Managing Traumatic Stress Risk: A Proactive Approach. She received the President's Award in Social Work in 1999 for the legislation that she wrote to create a statewide hotline now known as Cop2Cop and critical incident debriefings for law enforcement officers. She received the "Honored Citizen Award" from the New Jersey Honor Legion for her contributions to the law enforcement community. She has authored five legislative bills in New Jersey and has helped get two of them passed. One bill was introduced in Pennsylvania that would recognize a psychological injury as the same as a physical injury for the law enforcement community. Ms. Samuels is the author of the "Dear Steph" column for the New Jersey State Fraternal Order of Police Newspaper. Ms. Samuels got her Bachelors degree from UCLA, a Masters degree in Psychology from Antioch University, Los Angeles, and a Masters degree in Social Work from Rutgers University, New Brunswick.

Stephanie Samuels, MA, MSW, LCSW
Copline, Inc. Director and Founder
The Counseling and Critical Incident Debriefing Center, LLC
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Testimony focus areas are:

1. Best practices for Hotlines,
2. Non LEO vs. LEO hotlines and what is needed for success.
3. What happens after the Call and a referral is made?
4. Gatekeepers and barriers
5. Psychological injuries and worker's compensation

Committee Members:

Thank you for the honor of testifying before you today to address support services for Law Enforcement Officers. My name is Stephanie Samuels and I am here to testify as the founder of Copline as well as a Law Enforcement clinician in private practice.

Officers routinely risk their lives in service to their communities. Unfortunately, many officers do not trust that they will be taken care of when they need help themselves. That distrust continues to cost countless lives of those we rely on to keep our communities safe.

We know that Employee Assistance Programs and in-house counseling are not the answer for most Law Enforcement Officers. We also know that no matter how well-intentioned, "rescue" hotlines do not always follow best practices. They all breach confidentiality in perceived imminent risk situations, believing they are saving lives.

The Los Angeles Suicide Prevention Center (LASPC) has operated a 24/7 hotline since 1963. Their best practices have withstood the test of time. Between 1963-2019 LASPC fielded over 7,350,000 calls, of which they have had only two documented suicides. One of the founders, Dr. Edwin Shneidman was a professor of mine at UCLA, and I consulted with him extensively as I built the best practices for a LEO Hotline in NJ and then internationally. We know that statistically, people who call hotlines do NOT typically die by suicide. The key is to get the officer in distress to call.

The Los Angeles Police Department has been at the forefront of officer mental wellness for decades. The LAPD has partnered with Copline and its mission since our first training session of retired police officer peer listeners in 2017. Copline's lead trainer is Dr. Jay Nagdimon, a psychologist in the LAPD Behavior Science Services Unit and was the former Director of the LASPC, and therefore holds a unique dual expertise.

Copline volunteer training is an intensive 40 hour training in active listening skills and crisis intervention best practices (AAS, 2007/2013). We know that lay volunteers are better at helping suicidal callers than paid professionals (AAS, 10/16). Additionally, confidentiality MUST be assured, so NO connection to the government or an agency with a non-rescue component is essential. Copline adheres to this policy AND saves lives (call taker write up). If a Law Enforcement hotline operated with a rescue policy, it is unlikely any officer would call out of a fear their confidentiality would not be maintained as a result of the police attending the rescue call. FEAR prevents officers from reaching out to either hotlines or licensed professionals. However, officers are less likely to die by suicide and more likely reach out to a hotline, knowing it is manned by a brother or sister officer.

Copline is an international hotline answered by retired officers from across North America, thus ensuring a greater degree of anonymity. Getting officers to call the hotline is only the first step. The officer calling Copline may require a successful referral to a culturally competent therapist. Unfortunately, such therapists are few and far between. Even if the therapist treats trauma and PTSD as part of their practice, this does not give them the cultural competency essential to treat an officer effectively. Officers are reluctant to seek help and if they do seek help and the wrong help is provided, they are unlikely to try again.

Research over the past decade confirms that officers throughout the country are reluctant to get treatment (In Harm's Way Statewide Oct. 29-20, 2007, Governor's Task Force on Police Suicide-N.J. gov, 1/30/2009, IACP Breaking the Silence 2014, The President's Task Force on 21st Century Policing, May, 2015): "The primary barriers are a law enforcement culture that emphasizes strength and control, perceptions and distrust of mental health providers, the stigma associated with seeking help, general concerns about loss of privacy that may adversely affect their careers, and embarrassment or shame…(page 11, NJ Police Suicide Task Force 1/30/2009)

The next obstacle to effective service provision for law enforcement officers lies with insurance companies. They are the gatekeepers to private practice billing policies that limit clinicians and evaluate single case agreements with little to no insight into the confidentiality and specific service needs of an officer. Even where an out-of-network provider is authorized to ensure confidentiality, insurance companies monitor codes and the number of sessions, and ask for information that violates Health Insurance Portability and Accountability Act (HIPAA). (Health Integrated, 2006, BCBS 2008, Magellan 2010, Optum Health, 2012, Change Health, 2020).

In-network providers sign agreements that allow insurance companies to have access to a clinician's notes. Out-of-network providers often get audited and pressured to violate HIPAA codes. New Jersey has introduced legislation supported publicly by police officers and police unions that prevents this from occurring (A3955). In-network providers that refuse to cooperate have faced costly resolution expenses as well as investigations by the prosecutor/district attorney/attorney general's office and licensing boards. Compounding this issue is the reality that three of these agencies are law enforcement based. These agencies receive the names of the officers in treatment and often contact the patient (officer) to verify the sessions actually occurred, which further reinforces the officer's fears of potential confidentiality violations.

Another barrier to treatment is the worker's compensation system. Some states don't acknowledge psychological injuries and others like NJ have so many roadblocks to an accepted claim that the officers give up before they get the help they need to prevent chronic complex PTSD. Private Insurance cannot be billed in these cases, as there is an *"Employment? (current or previous)"* question on the claim form (Box 10 Universal claim form). The therapist is left with a daily no-win choice of "commit insurance fraud, or do pro bono work"?

It is my experience that we lose more officers after a critical incident from departmental insensitively and lack of appropriate psychological care than by the incident itself. We are also aware that many officers who have died by their own hands had previously been involved in critical incidents sometime prior to their suicidal crisis. (Tuckerton, 1/29/04, Robert O'Donnell 4/19/95, 5/8/96)

In conclusion, officers need to feel safe reaching out for help. A 24/7 CONFIDENTIAL hotline such as Copline is essential. The second key requirement is to identify culturally sensitive therapists and allow them to treat officers under "best practices" for this population, ensuring confidentiality of the officer in treatment. When an officer is injured psychologically or physically they must be able to receive competent and appropriate care. This approach allows the greatest chance of success in returning the officer to their pre-incident functioning level and achieving long term resiliency.

Thank you for the honor of testifying before this committee, as well as your time and dedication to being part of the solution.

Cherie Castellano, M.A., C.S.W., L.P.C., A.A.E.T.S.

Rutgers UBHC – COP 2 COP

Cherie Castellano, MA, CSW, LPC, AAETS is a national expert in the field of peer support after twenty years of experience as the creator of the "Reciprocal Peer Support Model" recognized as a national best practice by the American Psychiatric Association (2019) and Department of Defense Center of Excellence (2011.) Cherie began as the Program Director for Cop 2 Cop, the first legislated law enforcement crisis hotline in the United States. She is a voluntary faculty member of the Rutgers Department of Psychiatry where she has honed her clinical skills as an expert in peer support and law enforcement psychological services. She is also a member of the American Academy of Experts in Traumatic Stress. As the Director of Cop 2 Cop, Ms. Castellano has facilitated response to over 85,000 calls from law enforcement officers in need and the team at Cop 2 Cop has averted over 300 crises to date. The American Association of Suicidology certified Cop 2 Cop with the highest score ever awarded by that organization. Currently Cherie is the Rutgers National Call Center Peer Support Director leading more than a dozen peer programs for a variety of populations staffed by 150 peers and clinicians providing services on a state and national level yielding over five millions dollars of funding annually.

In 2018 Cherie was selected by the Director of the Bureau of Justice to serve on the National Consortium for Law Enforcement Suicide Prevention as a task force member to assist in the creation of recommendations to Congress based on the Law enforcement Wellness Act. Cherie and the Cop 2 Cop program were highlighted in a briefing in 2019 to Congress as national resources for the plans to address law enforcement wellness on a national level.

Over the last twenty years Cherie has "answered the call" replicating the Reciprocal Peer Support model for New Jersey law enforcement officers, Firefighters, EMS, Veterans, caregivers, teachers, child protection workers, Mothers of special needs children, as well as visually impaired and those suffering from addiction in need through more than 150,000 peer support contacts. The hallmark of her program's success has been the development her "Reciprocal Peer Support" (RPS) model using peers and clinicians as partners. Cultural connections, structured tasks and client centered strength based peer support are the key element to the RPS model.

Ms. Castellano has been recognized internationally as an expert in the field of peer support, behavioral healthcare and crisis intervention. Her experience as a lecturer has included international forums such as Australia and Europe as well as prestigious national forums such as the FBI National Academy. As a member of the 9/11 New York Emergency Services Delegation for the Port Authority Police Department she traveled to Ireland, Belfast and England to share "9/11 Lessons Learned".

Cherie co-authored two books "Psychological Counterterrorism and World War IV" with Dr. George Everly receiving national attention and "Law Enforcement Families; The Ultimate Back-Up" with Dr. Jim Reese. Cherie has authored several book chapters and over 100 articles in the field of peer support, law enforcement and military crisis intervention and has a column in The International Association of Counterterrorism & Security Professionals magazine.

Various awards include Governors Proclamations, NJ Governors Excellence Award, N.J. Attorney General Recognition Award, International Critical Incident Stress Foundation World Congress Award, Commerce Bank New Jersey Hometown Hero, Unico Woman of the Year, and the New Jersey Interfaith Coalition for the Disabled Lay Person Award for her faith based activity. Ms. Castellano was selected "People Who Made A Difference in 2005" Star Ledger. 2009 the Italian American Police Society of New Jersey "Woman of the Year" and she received the New Jersey Department of Military and Veterans Affairs Civilian Commendation Medal. Cherie testified to the Department of Defense Military Suicide Prevention Task Force to present the RPS model, and her programs were identified as a "Best Practice" in peer support by the Department of Defense Center of Excellence. Governor's Council on Mental Health Stigma Ambassador Award. In 2011 Cherie received the "Woman of the Year" Award by the National Police Defense League, also the "2012 New Jersey Health Care Hero" award by NJ Biz / Individual Education Award for founding and directing peer helplines and pioneering efforts in the field of Reciprocal Peer Support. In 2012 "Humanitarian of the Year" Lieberman award from The HealthCare Foundation of New Jersey" for her efforts with the "Mom 2 Mom" program. In 2017 awarded the New Jersey Department of Children & Families Commissioner's Partnership award for her leadership and partnership to serve NJ's children and youth. In 2018 Cherie received the Silver award for service innovation from the American Psychiatric Association.

Cherie served on Governor Codey's Mental Health Task Force, Governor Corzine's Task Force on Police Suicide, and has been a certified instructor for the International Critical Incident Stress Foundation, QPR for Law Enforcement Institute and is an appointed member of the Rapid Assessment Deployment and Recovery Team (RADAR) by the New Jersey Office of Emergency Management and Emergency Preparedness Task Force. Currently Cherie is serving on the National Consortium on Preventing Law Enforcement Suicide led by the Bureau of Justice and IACP.

Following September 11, Cherie coordinated a critical incident response to over 1,900 first responders in New York and New Jersey. Her crisis intervention services were featured in the New York Times as a "model for the nation." Utilizing a "Rescuer Victim" concept, more than three million dollars in grant funding was awarded by the Department of Defense Appropriation Act of 2002 for 9/11 victims. In September, 2004, Attorney General Harvey appointed Ms. Castellano to direct the "For You New Jersey 9/11" program serving eight million New Jersey residents impacted by 9/11. Ms. Castellano responded to the Hurricane Katrina Disaster First Responders and was awarded FEMA funding and national media coverage for these efforts.

In December 2005, Cherie transitioned her RPS peer model to a "New Jersey Vet2Vet" concept serving veterans and their families throughout New Jersey to cope with the psychological impact of war. In 2009, enhanced the federal Yellow Ribbon Guidelines in a "Welcome Home" Reconstitution project and Reintegration program utilizing her successful 9/11 "re-entry model" for the Port Authority Police Department. Cherie was selected to serve on the SAMSHA 2010 Returning Service Members, Veterans and their Families Policy Academy.

Cherie's peer programs were identified as a model for national expansion in 2011 with the "Vets4Warriors" peer support program serving 900,000 service members and their families across the USA. DCOE identified her model as a national best practice in peer support in a white paper in 2011.

A grant from the HealthCare Foundation of New Jersey funded a pilot of "Mom 2 Mom," a peer support program for Mother's of special needs children and adults. In 2013 the Mom 2 Mom program became funded by the New Jersey Department of Children & families serving all mothers of special needs children in NJ. With over 150,000 contacts and calls from mothers from 36 states a national expansion of Mom 2 Mom USA is underway." AID – NJEA Peer Support Program" which offers a "Teacher to Teacher" peer support experience is also being led by Cherie serving New Jersey Educators with Peer Support and Resilience Building activity along with Care2Caregivers were conceptualized and launched by Cherie supporting those who serve family members with dementia related illnesses.

"Worker 2 Worker" uses retired DCPP workers to serve existing child protection workers throughout NJ with peer support, resilience training, and crisis intervention services. Cherie's led a national webinar she led titled "Mind the Gap national Webinar Series- "Peer mentoring, Crisis Response & Resilience-building: NJ DCF's Worker 2 Worker Program hosted by the National Child Welfare Workforce Institute.

Cherie consults on multiple new programs that incorporate the Reciprocal Peer Support Model including designing a new helpline for Visually Impaired adults called "Eye 2 Eye" a new Horizon addiction peer support program entitled "New Jersey Peer Recovery."

Cherie was also integral in the creation of a Rutgers University certification program in Peer Support through the School of Health Profession.

As a Principal Investigator in a research grant Cherie has partnered with the University of North Carolina's "Global Peers for Progress Institute" leadership team to establish a program evaluation project for the RPS model and recently launched a grant focused on integrated care in peer support to develop a Wellness Coaching tool kit adaptation at Cop 2 Cop with national expert Dr. Peggy Swarbrick.

On a personal note, Cherie has devoted her career to "rescuing rescuers" and law enforcement families as she is married to Mark, a Detective Supervisor with the Morris County Prosecutors' Office, has two (2) sons Louis John and Domenick, and believes her role as a police wife and special mother are her greatest achievements.

Cherie Castellano LPC AAETS
Peer Support Program Director

Rutgers National Call Center & Cop 2 Cop Program

Focus: Peer Support, Crisis lines, Officer Wellness

It is my honor to share with you our lessons learned from twenty years of service with the Cop 2 Cop program. In 1999, the state of New Jersey passed the "Crisis Intervention for Law Enforcement" Act, the first and only one of its kind funded through forfeiture dollars annually to serve over 40,000 law enforcement officers and their families throughout the state.

We launched the program, Cop 2 Cop in 2000 using retired law enforcements officers as peers along with "cop clinicians" who were retired law enforcement officers and licensed clinicians located at the Rutgers University Behavioral Healthcare Access Center.

Since our inception, Cop 2 Cop has had over 80,000 contacts with officers using Reciprocal Peer support a national best practice model, trained over 10,000 officers in a Cop 2 Cop QPR suicide prevention course so officers can be their brother' s & sister's keepers, responded to critical incidents and mass disasters in the community with over 3,000 Cop 2 Cop face to face peer support contacts. We have received calls and supported officers from every state in the country, even though our program was originally designed to serve only New Jersey.

The Reciprocal Peer Support (RPS) model developed for Cop 2 Cop has led to the development of ten additional peer support programs at our National Call center for other high-risk populations. This model has also been identified as a national best practice by many noteworthy organizations, including the Department of Defense Center of Excellence, University of North Carolina Global Institute for Peers for Progress, the American Psychiatric Association, and by the Law Enforcement Mental Health and Wellness Act COPS Report to Congress just last year.

The RPS model focuses on high-risk populations with structured, clinically supervised peer support tasks: first is connection, second is information gathering & risk assessment, third is care management and wellness plans, fourth is resilience building.

Through the Cop 2 Cop RPS model, a caller receives a thorough telephonic exploration of needs and challenges and is offered three referrals from our Cop 2 Cop provider network of over 170 providers statewide. At the end of the initial call, officers are asked if they would like ongoing peer support. They say yes 70% of the time, at which point they are assigned a peer support specialist based on their sub specialty, such as chiefs, corrections, municipal or federal officers. A "best fit" Cop 2 Cop peer counselor is assigned and calls them weekly for an average of six months and fifteen contacts. More than 50% of our callers then report engaging in treatment referrals. Research has shown that the officers report an overall improvement in quality of life as a result of the service. Key positive attributes of the RPS experience include: connection based on a shared experience, emphasis on their strengths, focus on overall self-care- mind body- spirit, confidentiality helps to overcome stigma, informs Network development, identifies service gaps & needs, offers a continuum of support, we employ who we serve- the heart of the RPS model.

We recently placed a greater focus on the eight dimensions of wellness adopted by SAMSHA- Social. Environmental. Intellectual. Spiritual. Occupational. Physical. Emotional-to ensure a whole person approach to best support our callers' needs. Based on more than 87,000 contacts at Cop 2 Cop, the top ten problems officers are experiencing are: 1.)Depression 2.)PTSD**
3.) Anxiety, 4.)Other (such as work stress) 5.)Marital/Couples Issues, 6.)Substance Abuse 7.)Legal Problems 8.)Suicidal Ideations 9.)Medical/Somatic Complaints 10.)Family Issues/Parenting

Cop 2 Cop has been put to the test through a number of significant events. The program had only been operational for a year before September 11, 2001. As a result, our Governor deployed 9/11 Disaster Mental Health Services to targeted populations and Cop 2 Cop became the portal for support for over 125,000 first responders such as port authority police, firefighters, EMS workers and veterans and we established peer programs funded by 9/11 victim services.

In 2009, the New Jersey Governor's Task Force on Police Suicide invited Cop 2 Cop to be part of a stakeholder work group in response to a sudden increase in law enforcement suicides to explore national best practices and data regarding cause and effect. The outcomes were related to policy, marketing, training, and understanding high- risk populations.

In 2019, the New Jersey Attorney General created a directive to establish a Resiliency Program Officer Initiative for 800+ Resiliency Program Officers to be trained to offer coaching and be available in every law enforcement agency in our state serving alongside officers in need. When a risk factor or need is established beyond the resilience training, these RPO's will partner with the retired professional peer counselors at Cop 2 Cop to ensure clinical safety and services are provided. Cop 2 Cop will also "hand off" to the RPOs when an officer has completed counseling and needs to be sustained and supported in the community.

Our newest developments for Cop 2 Cop are based on the findings of a UNC research grant.

To address both the mental health and physical health of officers in need, we have added

Cop 2 Cop Wellness Plans to our peer support. This effort includes expanding the Cop 2 Cop provider database to include medical doctors with specialties targeted at law enforcement specific issues such as sleep, obesity and cardiac disease for a holistic, culturally-competent approach to law enforcement peer support.

After decades of effort, the lessons learned at Cop 2 Cop have led me to make three primary recommendations today:

1. The need to establish a National Cop 2 Cop Peer support program,
2. The need to establish a Law Enforcement Employee Assistance Provider (EAP) and Law Enforcement Community Provider certification and training capacity,
3. The need to replicate the New Jersey Resiliency Program for Officers nationwide

<u>Establishment of a National Cop 2 Cop Program-</u>Establishment of a national Cop 2 Cop/Peer Support helpline, with each state staffing their own services through a single point of entry, or by creating a National Law Enforcement Center of Excellence focused on peer support and officer wellness to function like a technical assistance center could be the foundation of this effort.

Officer's access to weapons warrants a robust and responsive crisis call capacity so using existing nationwide systems like the National Suicide Lifeline Network as partners across the country. In addition, a peer clinician partner model for law enforcement peer support is essential because of risk. Peer staff should include law enforcement retirees and wounded officers as their shared lived experience and reciprocal benefit to serving active officers is unparalleled. They are a national treasure. Similar to the Blue Star families program, a "Law Enforcement Family" special unit within a national Cop 2 Cop program should be established. Peer Support training and certification should follow the DCOE domains of learning with supervision and fidelity measures to maintain quality care. The Cop 2 Cop National Provider network must be maintained and expanded with criteria and other essential data collection capacity to ensure ethical, clinically driven referrals to care.

Most significant about this recommendation is that The Law Enforcement Mental Health & Wellness Act Report to Congress in 2019 addressed the issue of officer wellness based on a current best practice review with 22 recommendations. The establishment of a National Cop 2 Cop Program will meet 14 of those 22 recommendations.

Establishment of a Law Enforcement Employee Assistance Program (EAP) and Law Enforcement community provider certification or training capacity-Standardized, culturally-competent provider training is necessary to ensure appropriate services are available to officers and their families across the country. Unlike the VA, we do not have a national system of care for law enforcement officers, so our focus must be on the training of the providers already utilized by law enforcement systems across our country.

Employee Assistance Programs, are often underutilized by law enforcement officers, however the Establishment of a Law Enforcement EAP certification is needed to effectively serve the law enforcement population, and should include access to peer services.

In addition, we need to establish a Law Enforcement Community Provider training for providers across the country to include behavioral healthcare and medical services with an integrated care approach to the mind body connection.

The VA has led many immersion or specialty trainings for community providers to serve their veteran population effectively and we should replicate those efforts to ensure appropriate care for our officers and their families throughout the United States.

Establishment of Resiliency Program Officer Initiatives in Every State-Finally, I would recommend that we replicate the New Jersey Resiliency Program Officer Initiative in partnership with a National Cop 2 Cop program for a system that builds on the strength and resilience of our law enforcement heroes. The combination of active and retired peer support officers is the ideal continuum to emphasize resilience and wellness while offering access to quality accessible culturally competent care.

Although we are aware that law enforcement officers may see more human suffering in their first two years on the job than many civilians see in a lifetime, we also recognize these same officers heroically serve others while exposed to trauma often demonstrating tremendous resilience. Although we must address the need for services to officers in crisis, we also must acknowledge the thousands of resilient officers across this country serving and thriving as they are the models of wellness we strive to support as a way to promote a resilient law enforcement workforce.

Contact information: Cherie Castellano LPC, Rutgers National Call Center for Peer Support, Peer Support Program Director, Email: castelch@ubhc.rutgers.edu,Phone: 732 713 8037
Resources: Law Enforcement Mental Health and Wellness Act Report to Congress COPS, 2019.

Law Enforcement Mental Health and Wellness Programs COPS, 2019. 2018 APA Psychiatric Services Achievement Awards 2018, “Silver Award: Reciprocal Peer Support for Addressing mental Health Crises Among Police, Veterans, Mothers of Special Needs Children, and Others

Defense Centers of Excellence “Best Practices Identified for Peer Support Programs 2011. “Reciprocal Peer Support: A Not So Random Act of Kindness” 2011 international Journal of Emergency Mental Health, UNC Global Peers for Progress Website, New Jersey Attorney General Website October 2019 Resiliency Program Officer Summit, Vets4warriors.com, National Call Center for Peer Support at Rutgers brochure, New Jersey Police Suicide Task Force Report, Cop 2 Cop njcop2cop.com.

Dianne Bernhard

Concerns of Police Survivors (C.O.P.S.)

Dianne Bernhard, Executive Director of Concerns of Police Survivors (C.O.P.S.), retired after 23 years from the Columbia (MO) Police Department as their Deputy Chief of Police. Dianne is most proud of her work as a patrol officer, creating a camp for kids, a Crisis Intervention Team, a leadership academy, and reconstructing and managing a $19 million budget. Dianne was also a devoted member of the Columbia Police Mounted Team.

Dianne was first introduced to C.O.P.S. in 2005 when her co-worker and friend, Officer Molly Thomas-Bowden, was shot and killed on a traffic stop. Dianne says, "Witnessing the extreme grief in Molly's family and seeing C.O.P.S. embrace her family and healing and hope emerging, I became a believer in the power of the blue family." Dianne is proud to honor Molly while serving all of America's surviving family members and co-workers by ensuring the C.O.P.S. organization continues to be there for fallen officer's families and co-workers, for as long as they are needed.

Dianne Bernhard, Executive Director, Concerns of Police Survivors
Focus area: Police officer safety, health, and wellness

Concerns of Police Survivors, also known as (C.O.P.S.) was founded by 10 law enforcement widows in 1984 based on the concept of peer support. Simply put, those who have been through something similar are best equipped to provide support, advice and hope. Fast forward almost 36 years, C.O.P.S. now serves 53,000 members, all of whom have had their lives forever changed by a line of duty death (LODD). C.O.P.S chairs the National Police Week Committee where National Police Week is planned. Each May, survivors and law enforcement convene in Washington D.C. C.O.P.S. works directly with the National Law Enforcement Memorial Fund and the Fraternal Order of Police to arrange survivor attendance at the memorial events and to provide healing sessions for co-workers and family members of our heroes. Through our 55 chapters, C.O.P.S. responds to nearly every LODD across the country to offer immediate support, to assist with the filing benefits, and include survivors in our national network of peer support, unique to C.O.P.S. We offer twelve retreats for law enforcement survivors, surviving children, and co-workers, at no charge to the survivor or to the fallen officer's co-workers. We host 9 signature grant funded "Traumas of Law Enforcement" trainings regionally each year, host a National Conference on Law Enforcement Wellness and Trauma, offer scholarships to spouses and children of fallen officers and pay out of pocket expenses for counseling for children. In the past 5 years, the number of members served by C.O.P.S. has nearly doubled. We are growing at record pace. We may be one of the only membership organizations who never wants to add members.

I have served in my capacity at C.O.P.S. for the past six years, following my career at the Columbia Missouri Police Department, retiring as the Deputy Chief. I came to know of C.O.P.S. through the loss of my co-worker, Officer Molly Bowden, who was shot and killed in 2005. I saw first-hand how C.O.P.S. responded to help her family and does still to this day. I am going to testify about reducing LODD through move over laws and preventing heart attacks. I will also discuss recognizing Rhabdomyolysis deaths, and a future project for C.O.P.S.

In May of 2019 we honored 181 officers who died in the line of duty in 2018. Historically, we have averaged approximately 140 officers dying each year. While the rising number is due in part to the rise in violence against law enforcement, it is also fair to say there are also other reasons these numbers have grown. Our country has seen an increase in officers being shot in ambush attacks, and usually when the discussion is had surrounding LODD, the emphasis centers around these felonious deaths. According the C.O.P.S. records, in 2019, of those honored at Police Week, felonious death comprised only 32% of those honored. The deaths of 68% of the officers were caused by other means. The most common of these other means include car crashes, heart attacks, and cancer deaths related to the response to the 9/11 terrorist attacks.

In 2018, 45 officers were killed in vehicle crashes. We continue to see the need for education for officers surrounding speed and distracted driving. There is also a need for an educational push for enacting "move over laws" in states in which they do not already exist, and the aggressive marketing and enforcement of laws that are in existence. To provide you context of how big of a problem this is, in 2019, in the State of Illinois, there were 27 Illinois State Troopers struck roadside, as a result of an uninvolved motorist failing to "move over". Two of those officers, Trooper Brooke Jones-Story and Trooper Christopher Lambert were tragically killed in 2019.

In 2018, 18 officers died as the result of a heart attack. Dr. Jon Scheinberg, a cardiologist, a LT with the Cedar Park Texas Police Department, and the Medical Director of the Central Texas Regional SWAT, presents shocking information about the life expectancy of a police officer--which is 22 years less than the general population. He warns that the average age of an officer suffering a heart attack for the first time is 49 while the average age of the general public suffering the same event is 65. Perhaps, the most shocking statistic he cites is the chance of dying from a heart attack between ages 55-59 is 1.6% for a civilian but is a shocking 56% for a police officer. Dr. Scheinberg attributes the increased prevalence of hypertension, diabetes, obesity, and shift work with inherent poor sleep cycles. Perhaps the most significant factor, is a stress pattern unique to law enforcement—working sedentary most of the time paired with sudden adrenaline streaks. Dr. Scheinberg asserts with proper testing, diagnosis and treatment, many heart attacks in law enforcement could be prevented. He encourages every law enforcement officer to have a test done to obtain their Coronary Calcium Score and coronary inflammatory markers. Costing around $100, these tests can lead to early detection of heart disease and medication being prescribed to offset the risks. Requiring these tests may have an immediate effect in lowering the number of deaths.

I would also encourage this Commission to consider addressing law enforcement deaths by Rhabdomyolysis. Rhabdomyolysis is a medical condition in which, after acute stress and strain, the body temperature rises, skeletal muscle tissue breaks down and toxins are released into the blood, ultimately result in multiple organ failure. Nearly every year there is an officer who is injured or dies after physically asserting themselves during an extreme training exercise or physical testing process. For example, Officer Rogerio Morales, a healthy 27-year-old officer of the Davie Florida Police Department was participating in SWAT team tryouts, mandatory to be on the team. The course consisted of a rope climb, rope swing, a set of under bars crawl, crossing a 30 foot section of logs, over and under two sets of three fences, an 8 foot wall to jump and climb over, an A-frame approximately 10-feet tall to climb up and down, pull up bars, concrete tube crawl and a half mile run with other obstacles. Officer Morales completed the first round through this obstacle course and the half mile run without any problems and was in the lead of the other officers. During his second time through the course he collapsed and became unconscious. He suffered from heat stroke, metabolic acidosis and had a body temperature of 102.6. He died two days later from Rhabdomyolysis.

Officer Dan Ackerman, a healthy 31-year-old officer from the Buena Park California Police Department went to a mandatory physical obstacle course, similar to what was described for Officer Morales. After completing the obstacle course successfully Officer Ackerman collapsed and died 19 hours later from exertional rhabdomyolysis and heat exhaustion.

Officer Afolayan, a 29-year-old physically fit man was attending the United States Border Patrol Academy in Artesia, New Mexico, where the daily temperature averaged in the 90s. After participating in sessions of physical training over several days, Officer Afolayan sought treatment 6 times for muscle pain, dizziness and weakness. He was released after being charted as having cold like symptoms. He continued to train during the academy. After he participated in the final mandatory 1.5-mile run, well under the required time, he became disoriented and collapsed. Even with medical intervention, he died 32 hours later.

What is in common in each of these cases is their families did not receive federal PSOB benefits as their conditions did not qualify as an “injury” in the PSOB law and regulations.

I do not bring these to your attention to be critical of the PSOB staff. They are regular partners of C.O.P.S., and we work together on gathering the information needed to pay claims. We have found that within PSOB, if the case is determined to be able to be paid within the law, it is. Legal advisors have looked at these cases to determine if they fit within the definition of "injury" under PSOB law. In these cases, it appears the injury definition needs to be changed to include scenarios such as what happened to these three officers. These families should receive the financial support due them because of how their officers died. Common perception of most police officers and citizens who hear of these officers' deaths would be that these deaths should be considered in the line of duty. There is little doubt these officers would be alive today if they had not participated in the mandatory law enforcement training activities. We do understand the need for physical training and have no criticism of these departments for having programs to ensure offices are fit enough to participate in the rigorous activities necessary to be a police officer, or those duties more stringent of being a SWAT officer. We do encourage this commission to consider making sure agencies are well-trained in the signs and symptoms of Rhabdomyolysis. Saving lives is the first priority. We also respectfully request the assistance of this important Commission in changing the PSOB rules and regulations in a way that the families of heroes such as Officers Morales, Ackerman and Afolayan receive the federal benefits that should be afforded to them.

Last, I would like to acknowledge that not all officers who die as a result of wearing a badge die in the line of duty. Too many officers, after suffering the effects of the job, tragically end their own lives. Our C.O.P.S. staff and counselors spend a lot of time with law enforcement officers in our training sessions and during our retreats. There is a myth that law enforcement officers will not talk about issues they are experiencing. It is simply not true. Officers when given a safe environment, with someone who can relate to what they are going through, and they know their jobs are not on the line, will talk. Peer support programs and professional therapy, such as EMDR, through culturally competent law enforcement counselors works. Mental health check-ins should be preventative in nature and proactive instead of reactionary. The biggest challenge we are seeing which law enforcement needs to overcome, is figuring out how to provide that environment viewed as safe by the officers.

Nearly every week, C.O.P.S. receives calls from survivors and co-workers of officers who have died by suicide asking for assistance from C.O.P.S. Law enforcement agencies are at a loss as to how to provide support. After an officer suicide, the resulting issues and concerns of their survivors and co-workers often differ greatly from those of LODD survivors. They sometimes experience feelings of shame, guilt, and at time are initially considered a suspect in their loved ones' death. The stigma of suicide is very real and is not felt to the same degree by LODD survivors. Because of this, at C.O.P.S., we have been reluctant to set up programs intermingling the survivors of suicide and line of duty death. Peer support works best with people going through nearly the same thing.

In January of this year, the C.O.P.S. National Board decided to assist in the creation of a totally separate suicide support organization that, over time, will mirror the C.O.P.S. organization. It will be a stand-alone organization but will grow based on the lessons learned within the C.O.P.S. organization. This new organization missions will be to provide peer support for families and co-workers of officers who commit suicide. It will not pursue federal benefits. C.O.P.S. LODD survivors who have benefited from the programs at C.O.P.S. have seen an opportunity to pay it forward to those suicide survivors who have had very little support over the years.